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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 89 Number 1 June 1992

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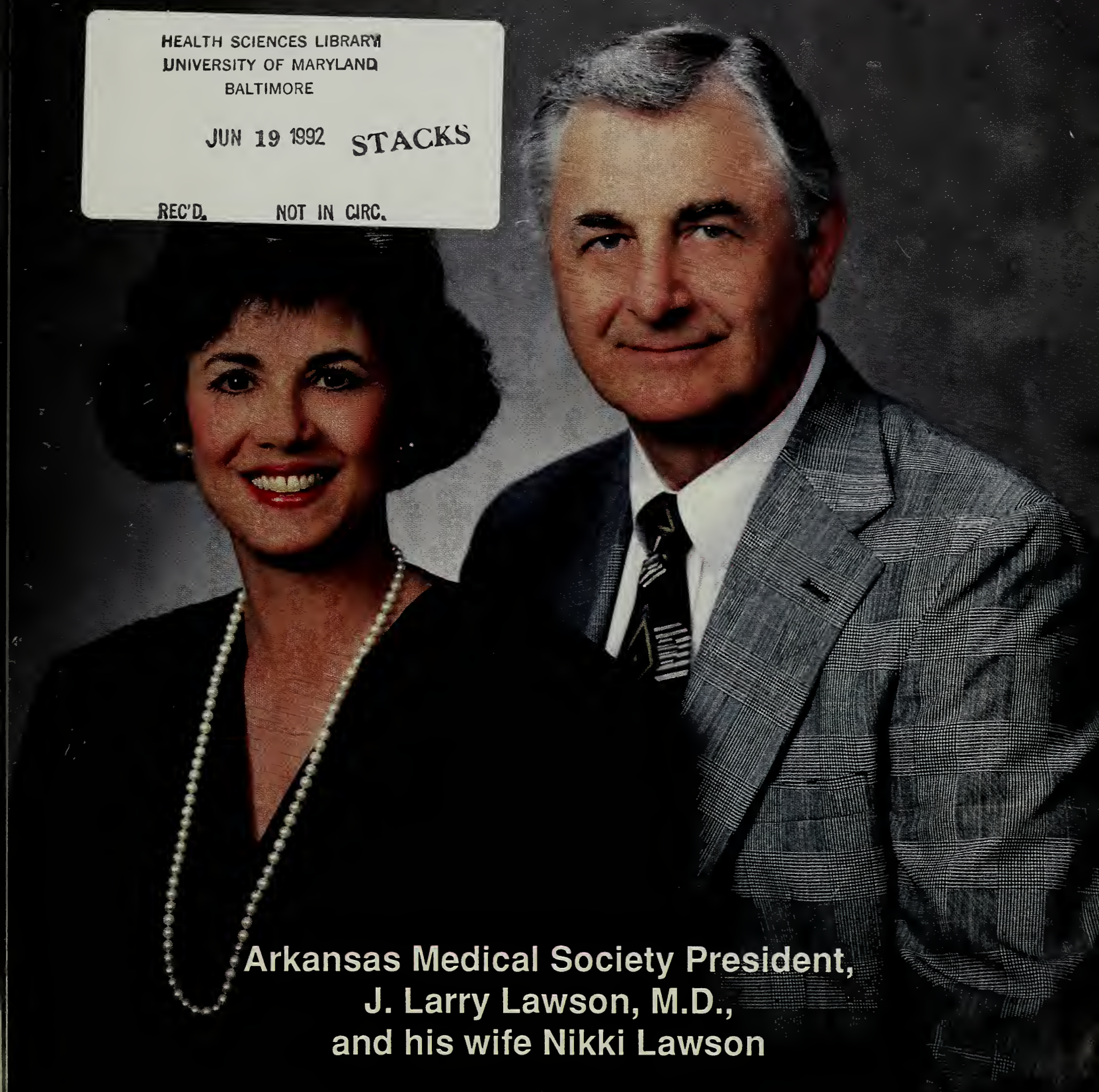

Arkansas Medical Society President,
J. Larry Lawson, M.D.,
and his wife Nikki Lawson

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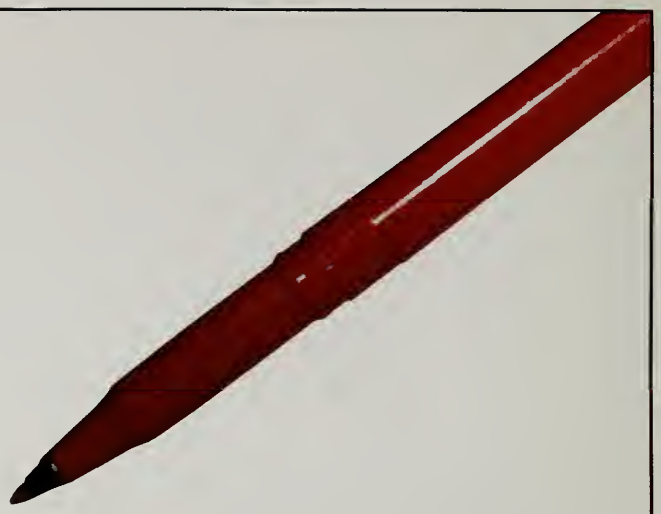

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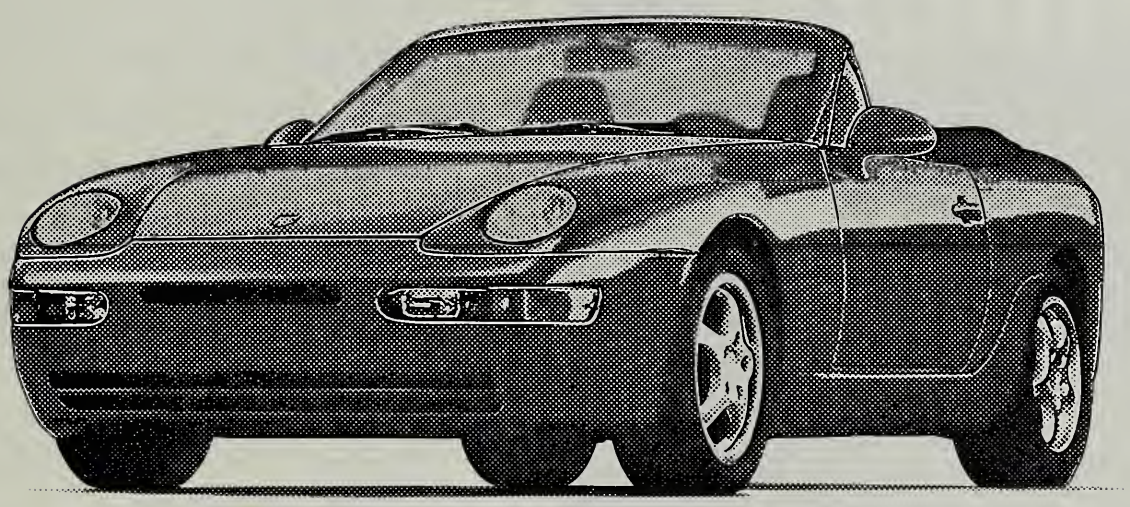

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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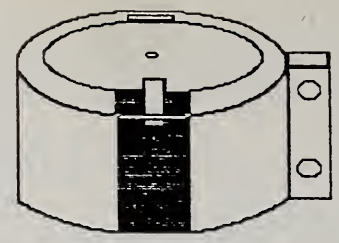

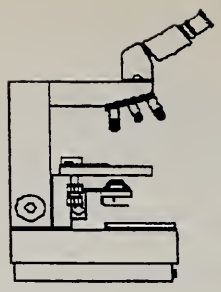

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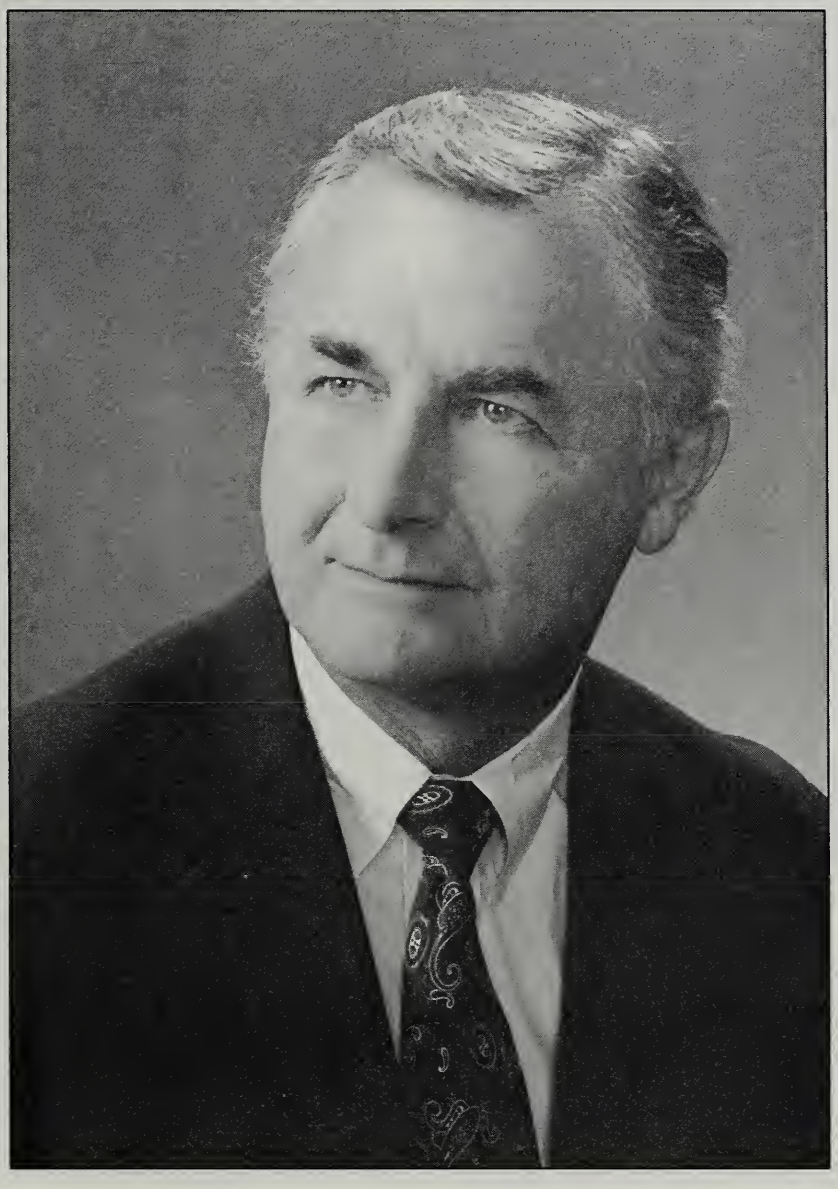

J. Larry Lawson, M.D.

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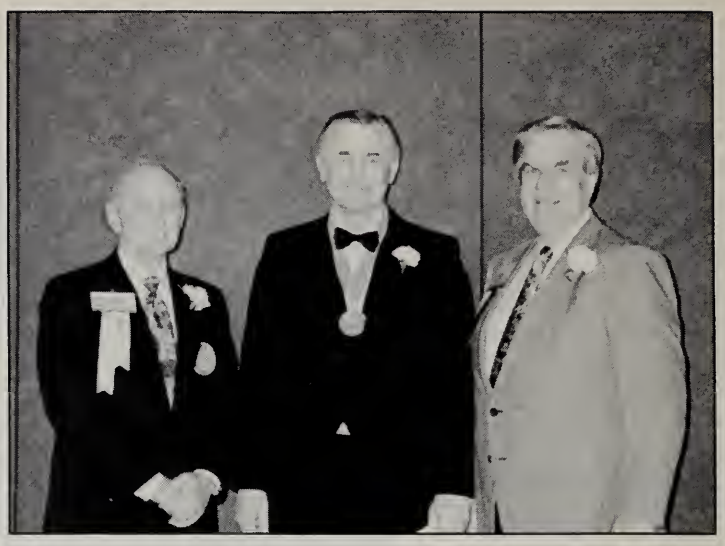

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Inaugural Address

J. Larry Lawson, M.D.
President 1992-1993

Dr. Warren, fellow physicians, members of the Auxiliary, family, friends, and other invited guests:

It is an honor to serve as president of the Arkansas Medical Society for the coming year.

The practice of medicine over the past 20 years has become increasingly frustrating. If there is anyone in this room who disagrees with this statement — we have arranged counselling for you across the hall!

Through these years, we have been castigated from all corners of our society. In some cases, justifiably the resulting chaos deserves some comments to avert a self-imposed guilt trip. I have attended medical meetings at all levels over the past 15 years. Without exception the speakers have lectured and discussed our medical system, but to my knowledge I have never heard any comments toward a solution. This observation was made again recently in Los Angeles at a four-day meeting sponsored by the AMA called a "Leadership" meeting. Critics from Washington to Little Rock have said that all our health care problems are because of bad doctors, I want to exercise the privilege of this office and relate some thoughts that summarizes the events that brought us to this point in our history.

My qualifications are that I was a student for 27 years and then practiced medicine for 25 years. First, where are we getting our new doctors? I have observed that medical students have always been in a frenzy to get through high school, college, medical school, and then their post graduate training. Their teachers are anxious. Their relatives are anxious. A student arrives at medical school at age 22, graduates as late as 26, out of residency at 30. There was no time to grow up, and no time to study the languages, philosophy, theology, economics, political science, or even the social graces. These things are extremely important to sustain a society. Our patients have noticed this lack of depth in our newer physicians.

We turn out doctors of medicine, then issues come across the country such as euthanasia. A committee is assembled and a physician may be asked to be on the panel because this deals with life and death. Suddenly we are listening to a doctor expound on his beliefs who has studied physics, chemistry, and biology, actually has repaired a hernia or done a spinal tap, but has no knowledge of the humanities above freshmen English. Could this be why our governor recently appointed an ethics committee without a physician being named to the panel? This may be why Dr. Kenneth Keown, Professor of Anesthesiology at the University of Missouri, used to remind us that a doctor may still have the right to be heard — but not necessarily the right to be taken seriously!

Let's look for a moment at the medical schools. We need to return to producing physicians. I have heard students say, "I don't want to take thus and so, all I want to do is be a doctor." That is really what we are doing, turning out doctors, but very few physicians. I attended a chief residents meeting at the University of Wisconsin

in 1966 and the featured speaker was Dr. Flexner. He was the son of Dr. Abraham Flexner who wrote a treatise in 1925 on medical education. This epic paper became the basis for the finest medical education system in the history of man for the next five decades and separated the physicians from the charlatan. I examined his 1925 manuscript.

He recommended that the first year of study should include anatomy, physiology and physiological chemistry. The second year - physiology, bacteriology, pathology, pharmacology, and physical diagnosis. This rings a clear bell because most of the physicians in this room were trained in this manner. The third year — obstetrics, medicine, surgery, clinical microscopy, and clinical pathology. The fourth year - medicine and surgery including clerkships and one elective. I have talked to several medical students across the United States and this is not the case now — and has not been for a number of years.

We are now sending people out on preceptorships after their first year. I do want to say that our particular medical school has made great strides encouraging preceptorships and has an impressive percentage of

students doing this. Unfortunately, this is done so early in their career that it is helping little with their understanding of clinical problems, what they would hope to do — or more importantly, where they would do it. I would recommend a mandatory preceptorship and this should be after their junior year. Every effort should be made to have this experience with a family doctor in a smaller community. This historically has had a significant influence on the types and locations of practices.

The rotating internship appears to be extinct! The rotating internship was the primary selection of all graduates when most of us finished medical school. There wERE a few straight and mixed internships, but today internships are called transition years. I am not sure from where they are transitioning or to what! It appears to this observer that most students have made a declaration of a subspecialty one to two years prior to this point in their medical training. It is imperative that graduates of medical schools should first be a physician before they are allowed to make any other career decision.

I am aware that to accomplish this program in the student's development, we would have to do away with the residency matching program until the year of the internship. This is what I would like to see accomplished and to get these students' minds away from thinking they want to do some high pay - high specialty practice before they know the total picture. There are ways for the patient to fall through the health care net other than lack of access — try for example the physician's lack of a broad medical knowledge! We have fallen into the government's trap and have now become only another health care provider who happens to have a medical degree.

I finished medical school when I was 30 years old but had no idea what I wanted to do when I grew up. I called five physicians in different types of practice and asked them what type of internship they recommended. All of them told me I needed to be a physician first and that could only be done by doing a rotating internship. My sister-in-law, Nancy Lawson, whom you just met, probably does not remember asking me this question 25 years ago.

Being an educator, she wondered how doctors could finish school, get their training, get out of the school environment and then know how to treat patients. I explained the step-wide educational background endured until you received your degree; then the final training with a rotating internship where you are the responsible physician, see the various areas of medicine and get a last look at the overall picture. She agreed and wondered why this couldn't be designed into the education of teachers. It is curious that while we have narrowed our medical school program to subspecialties that two years ago Trinity University in San Antonio initiated an internship for teachers! Early reports show that the quality of the teacher is far greater than simply another year of training. It also appears their internship is putting them into an enviable position from the standpoint of demand.

I want to emphasize the recommendation to slow down. We have plenty of doctors in this country. Our problem is mal-distribution in types and locations of practices. Until we slow down, become educated to our professional charge and allow our students to experience all the areas of opportunities that are available, we will continue to have this serious problem.

To illustrate my impression of the lack of breadth and depth of today's graduates, I would like to relate a true story of 5 years ago. A recent graduate who had not

experienced the broad training that I am recommending called me from a town 30 miles away. He was trying awkwardly to describe a patient he wanted me to see. He made several comments about a 3 year old, none of which were relevant to his degree of illness. After several questions and still not hearing any description to give me an indication that I might be the consultant he was looking for, I said, "Doctor, I am not sure what this patient's problem is, could you simply tell me what he looks like?" There was a pause and it was obvious he was grasping for an answer when he said, "Well, he looks an awfully lot like his mother."

There needs to be some relevance to education, but national boards seem to be taking away a considerable amount of initiative and individuality that medicine has thrived on these past 100 years. Arkansas has always turned out doctors who have competed well nationally. I am concerned that since the national boards have come into being, and our scores have improved so dramatically each year, that we are addressing testing at the expense of education.

My brother Noel, who is a medical educator, also fears that we are teaching "to the test" on a national basis and not to what is needed to practice medicine. The government, THE insurance companies, and THE plaintiff attorneys are all pushing for standardized care for an unstandardized populous. Stephen Gould, the anthropologist, warned — "Beware the uncriticised consensus — it is the sign of impending trouble." I say, when dissention is not allowed within the realm of science and art, you are then dealing with an ideology — which is neither a science nor an art! I cannot agree to standardization of productive minds.
"Teaching to the test" equates the practice of medicine to that of a public utility such as electricity or sewage.

I am concerned about student loans. Last summer, I served on a student loan committee and was appalled by the number of students who were already 40 to 50 thousand dollars in debt and were asking for another $12,000. I felt very proud throughout the meeting that we were answering these students needs, but as I reflected on this over the next several weeks, I developed a guilty feeling. The student we loaned the additional $12,000 to will graduate with a $62,000 debt at 10% interest. The public is concerned about doctors over billing, over charging, and over utilizing. Picture yourself starting out in a practice with no debt or a minimal debt and being able to use your good judgement and character in managing a patient. Then compare another graduate who let's assume has equal character and discipline, but is facing his first day of practice with a $62,000 debt at 10% interest. I will ask you the same question that bothers me — What are the chances of this second student's character being dramatically challenged in his patient's management? I do not have the answer for this. We cannot dictate to students how they should live, but I think we will have to consider some type of limit on our participation in student loans for the protection of both the student and eventually the patient. It is ridiculous to put medical students into such bondage that they must seek high pay to clear their debt.

Obviously our society has changed for many reasons that I cannot enumerate. The goal of our current students, though very intelligent and good people, differs from what their purpose should be in going to medical school. I have interviewed several current students on this subject and it appears that they really don't know what I am talking about. One student actually ended the conversation by saying, "Yes, the idea of service has changed and, in fact, getting an acceptance to medical school is like completing a business deal."

Without any question, medicine does not have the satisfaction today that it did 20 years ago. (By the way, are most of the folks back from counseling?) We are accused of everything from larceny to deception and malpractice but even if we have no guilt, we are preoccupied with trying to stay out of these areas creating an immediate barrier to the desired doctor/patient relationship. We used to actually be concerned about the legal problems that were brought to us, but that has almost become a non-issue in relation to what our elected officials have done to us in Washington.

Dr. Milton Friedman, the Nobel Prize Economist, said recently in the Wall Street Journal, "Government needs to get out of medicine." This doesn't shock anyone here, but he gave a very concise reason for this. I would add that we have been some 25 years getting into this mess to serve what in 1965 represented only 10% of the population over age 65.

Government intervention into medicine is probably the most inflationary event that has ever happened to

this country. I recommend that the government spend the next 25 years getting out of the business of medicine. If they receded from this intervention at a 4% level each year, in 25 years they would be 100% out of the business.

The people at age 40 and below would have adequate time to prepare for their future as our parents had prior to 1965. Currently the intent of the government is to continue to squeeze until they hope to make the doctor feel grateful to have socialized medicine. The private insurance companies are falling in line with the government, seeing how much they can get by with from their customers, seeing how much the physicians will tolerate and then close in on us from the private sector. Doctors have a choice of succumbing to this process while not realizing that they are the only people in the United States who can practice medicine.

The immediate rebuttal is, if we don't accept these demands by the government then they will not allow us to practice medicine. Tell me who is going to practice medicine if doctors can't? Someone will say they will fine you and put you in jail if you don't play their game. I am asking where are the extra 600,000 jail cells to incarcerate these wayward physicians?

For you who haven't read the fine print, we can go to jail for five years and enjoy a $250,000 fine even if we take care of a Medicare patient free! The government will not allow us to manage a Medicare patient any differently than a private patient. This includes having to bill the patient! Very soon, organized medicine or some physician will have to come forth and lead a quiet disassociation of all physicians from participation in third-party payments. The insurance policies we currently honor are contracts between the companies and their customers — not between us and our patients. We have lost control of this aspect of our practice in what we used to call the free enterprise system. Private practice is now involved in a discount, everyday low price scheme, that is the envy of even our best known discounter. We are now serving the third-party and not the patient. When this disassociation is done, there will have to be reasonable and prudent fees which are not based on the fantasy world under which we are currently struggling.

Physicians have to be competitive from within to resume the original American system of delivery. This is not a plea to lessen the role of our state medical boards but probably to expand their responsibilities.

A new world of business will open for people like my daughter, the prospective attorney looking for a case. For example, there is a group of elderly patients on the east coast who are filing a suit against the government because it will not allow Medicare patients to exercise private contracts. I am anxious to watch this develop. The public needs to understand that the government has done nothing to reduce the cost of health care, but quite the contrary — they simply have reneged on their promise to pay — the cost continues! Some people argue that no one can get together and create a reasonable fee schedule because of the Sherman Anti-trust Act. First, the government has violated its own law — it has already set its own fees. Second, the other third-party payors are immune from the anti-trust law due to the McCarren-Ferguson Act. Therefore, they can also set your fees. The irony is, we get the infamy for the fees, yet the same law will not let us set our own fees. Third, if you really believe that the Sherman Anti-trust Act was passed to prevent monopolies, try to go home Monday and start your own electrical utility or open your own post office.

If some of you were on a brief trip to Bermuda the last couple of minutes, let me refashion what I just said. No one since 1965 such as your Congress, legislature, governors, or private business has stepped up to reverse this socialization of medical practice.

After these 27 years, who do you think is going to resolve this issue? It is clear to me that the entire answer is in the hands of the physicians. There is no other party who has our interest! Nearly every doctor I have talked with gives me a discouraging alibi about doctors not cooperating to get this reversal carried out. If I thought they were correct — the solution would be straightforward — we would SIMPLY disband as a profession and practice at the direction of the public.

In another era — and in another setting — where some of you were fighting — it was December 4, 1950, at the Chosin Reservoir in North Korea. 10,000 troops of the first marine division were suddenly surrounded by 120,000 Chinese troops who were backed up by another 300,000 of the enemy. General Oliver Smith, being a prudent commander, gave the order to return to HungNam, their point of origin. The war corREspondents goaded the general that the United States Marines never retreat! His now famous remark was — retreat hell, we're just advancing in another direction!

This is where medicine is today! We are 600,000 physicians surrounded by 250 million deserving people who are not getting the medical attention they need. We are taking the pounding broadside on this entire issue. Though the odds are heavier than they were in Korea, when we take care of our own affairs and return to our own point of origin, we will turn this problem around to everyone's advantage.

I appreciate your forbearance for this moment's comments, and the honor of being here. It is the privilege of the new president to express his thoughts — and I have enjoyed reviewing in a brief manner the history of what got us where we are and the steps as a national organization that we will have to take to continue as an honored profession.

Thank you for giving me something very important, the last 31 minutes of your time. ■

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1992 Arkansas Medical Society Annual Session

	Officers	First Session	Second Session
Speaker	John Crenshaw	present	present
Vice Speaker	Kelsy J. Caplinger III	-	-
President	George W. Warren	present	present
President-elect	J. Larry Lawson	present	present
Vice President	Michael N. Moody	present	present
Secretary	Charles H. Rodgers	present	present
Treasurer	James M. Kolb Jr.	present	present

	Councilors	First Session	Second Session
District 1:	Dwight Williams	-	present
	Merrill J. Osborne	present	present
District 2:	John E. Bell	present	present
	Lloyd Bess	present	present
District 3:	L. J. P. Bell	present	present
	Hoy B. Speer Jr.	present	present
District 4:	Lloyd G. Langston	-	present
	Paul A. Wallick	-	present
District 5:	Wayne G. Elliott	present	present
	Robert Nunnally	present	present
District 6:	James D. Armstrong	present	present
	F.E. Joyce	present	-
District 7:	Ronald J. Bracken	present	present
	Thomas H. Hollis	-	-
District 8:	Glen Baker	present	present
	David Barclay	-	-
	Paul Cornell	present	-
	Charles Logan	present	present
	R. Jerry Mann	-	present
	Harold Purdy	present	present
	Robert Shannon	present	present
District 9:	Robert H. Langston	present	present
	David L. Rogers	present	present
District 10:	Gerald A. Stolz	present	present
	Morton C. Wilson	present	present
	Paul Wills	-	-

	Past Presidents	First Session	Second Session
1979-1980	A. E. Andrews	present	present
1971-1972	C. Stanley Applegate	-	-
1985-1986	John P. Burge	present	present
1983-1984	Asa A. Crow	present	present
1964-1965	C. Randolph Ellis	present	present
1969-1970	Ross E. Fowler	-	present
1951-1952	Charles R. Henry Sr.	-	-
1982-1983	Morriss M. Henry	-	-
1988-1989	John M. Hestir	-	present
1990-1991	William N. Jones	present	present
1987-1988	W. Ray Jouett	present	present
1976-1977	Albert S. Koenig Jr.	-	-
1977-1978	W. Payton Kolb	present	present
1980-1981	Kemal E. Kutait	-	-
1986-1987	Ken Lilly	-	-
1967-1968	Joseph A. Norton	-	-
1974-1975	Ben N. Saltzman	present	present
1981-1982	Purcell Smith Jr.	-	-
1968-1969	H.W. Thomas	-	-
1975-1976	T. E. Townsend	-	-
1963-1964	Joe Verser	present	present
1972-1973	C. Robert Watson	-	-
1989-1990	James R. Weber	present	present
1984-1985	Charles F. Wilkins Jr.	-	-
1973-1974	John P. Wood	-	-
1978-1979	George F. Wynne	present	-

House of Delegates Composition

	Delegates	First Session	Second Session
Arkansas (1)	Marolyn Speer	-	present
Ashley (1)	C.E. Ripley	present	-
	D.L.Toon	-	present
Baxter (2)	Robert L. Baker	present	present
	John Guenthner	-	present
Benton (3)	William T. Summerlin	-	present
	Larry D. Wright	-	present
Boone (1)	Carlton Chamber	present	present
Bradley (1)	Joe H. Wharton	present	present
Carroll (1)	Oliver Wallace	present	present
Chicot (1)	Pete DeRamos	-	-
Clark (1)	Noland H. Hagood	-	-
Cleburne (1)	J. Warren Murry	-	-
Columbia (1)	H. Scott McMahen	present	-
Conway (1)	NOT REPRESENTED	-	-
Craighead/ Poinsett (6)	Jerry D. Blaylock	-	-
	M. Lowery Beck	present	-
	Joe H. Stallings Jr.	present	present
	Don B. Vollman Jr.	present	present
	Joe T. Wilson	-	present
Crawford (1)	Millard C. Edds	-	-
Crittenden (1)	G. Edward Bryant	-	present
Cross (1)	NOT REPRESENTED	-	-
Dallas (1)	Don Howard	-	-
Desha (1)	NOT REPRESENTED	-	-
Drew (1)	Harold Wilson	-	present
	William R. McKiever	present	-
Faulkner (1)	J. J. Magie	present	-
Franklin (1)	David L. Gibbons	present	present

House of Delegates Composition - cont'd

	Delegates	First Session	Second Session
Garland (5)	Lee Atherton	present	present
	Michael Finan	-	-
	Charles Larrison	-	-
	Tim English	present	-
	Mark Russell	-	-
Grant (1)	NOT REPRESENTED	-	-
Greene/Clay (1)	Roger Cagle	present	present
Hempstead (1)	Lowell O. Harris	-	present
Hot Spring (1)	NOT REPRESENTED	-	-
Howard/Pike (1)	Joe King	-	-
Independence(2)	John R. Baker	present	present
	William J. Waldrip	present	present
Jackson (1)	John D. Ashley	-	present
Jefferson (4)	Simmie Armstrong Jr.	present	present
	Lee A. Forestiere	-	-
	David Jacks	present	present
	Anna T. Ridling	present	present
Johnson (1)	Donald H. Pennington	-	-
Lafayette (1)	Sanford E. Hutson	present	-
Lawrence (1)	Ralph F. Joseph	-	-
Lee (1)	NOT REPRESENTED	-	-
Little River (1)	Joe G. Shelton	-	-
Logan (1)	John R. Willliams	-	-
Lonoke (1)	Leslie F. Anderson	-	-
Miller (3)	John A. Gillean	present	present
	Joseph R. Robbins	present	present
	Herbert B. Wren	present	-
Mississippi (1)	Joseph V. Jones	present	present
Monroe (1)	Linda C. Collins	present	present
Nevada (1)	Charles Vermont	-	-
Ouachita (1)	William D. Dedman	present	present
Phillips (1)	L.J.P. Bell	present	present
Polk (1)	M. Byron Page	present	present
Pope (2)	H. Kevin Beavers	-	present
	Kelly H. Meyer	-	-
Pulaski (32)	Durwood B. Allen Jr.	-	-
	Joseph M. Beck	present	-
	Raymond V. Biondo	present	present
	Amail Chudy	present	present
	Bob E. Cogburn	-	-
	Gilbert O. Dean	present	present
	James K. Dilday	present	-
	Jim English	-	present
	Charles P. Fitzgerald	-	-
	William E. Golden	-	-
	James L. Hagler	-	-
	Edwin Hankins III	-	-
	Fred O. Henker III	present	present
	D. Andrew Henry	-	-
	C. Reid Henry	-	-
	Anthony D. Johnson	present	present
	Carl L. Johnson	present	-
	William D. King	-	present
	Marvin Leibovich	present	present
	Fred Nagel	present	-
	George A. Norton	-	-
	Walter O'Neal	present	present
	J. Mayne Parker	present	-
	Carl J. Raque	present	present
	John F. Redman	present	present

	Delegates	First Session	Second Session
	Ashley S. Ross Jr.	-	-
	Edward H. Saer	-	-
	John Satterfield	-	-
	Bruce E. Schratz	present	present
	Frank M. Sipes	present	present
	William L. Steele	present	present
	Robert Valentine Jr.	-	-
	John L. Wilson	-	-
	Paul W. Zelnick	-	-
Randolph (1)	NOT REPRESENTED	-	-
Saline (1)	Marvin N. Kirk Jr.	-	-
Sebastian (9)	Jimmie Atkins	-	present
	David B. Kocher	-	-
	A. Samuel Koenig III	-	-
	McDonald Poe	-	-
	John R. Swicegood	-	present
	John Wikman	-	-
	Carl L. Williams	-	-
Sevier (1)	NOT REPRESENTED	-	-
St. Francis (1)	Samuel A. McGuire	present	present
Tri-County (1)	George W. Jackson	present	present
Union (2)	Gary L. Bevill	present	-
	Allan S. Pimique	-	present
	Robert C. Tommey	present	present
Van Buren (1)	John A. Hall	present	present
Washington (5)	Hershel Garner	-	-
	Anthony Hui	-	present
	William McGowan	present	present
	William B. Nowlin	present	present
	Terrill Oretego	-	-
	Janet Titus	present	present
White (2)	Daniel S. Davidson	present	present
	Clark Fincher	-	-
	William White	-	present
Woodruff (1)	James E. Rowe	-	-
Yell (1)	James L. Maupin	present	-
Resident Physician Section (1)	NOT REPRESENTED	-	-
Medical Student Section (1)	Elise Fortin	-	present

The Changing World of Medicine

Arkansas Medical Society 116th Annual Session
Excelsior Hotel ▫ Statehouse Convention Center
Little Rock, Arkansas
April 9 - 11, 1992

House of Delegates
First Session - April 9, 1992

Speaker of the House John Crenshaw called the House of Delegates to order on Thursday, April 9, 1992, at the 116th annual meeting of the Arkansas Medical Society.

The Arkansas National Guard presented the colors and Dr. Hampton Roy, Little Rock City Board of Directors, greeted the House. Dr. Roy presented Dr. George Warren with a key to the city of Little Rock.

Dr. John Burge introduced Mrs. Sancy McCool, AMA-ERF Chairman of the American Medical Association Auxiliary. Mrs. McCool addressed the House.

Speaker Crenshaw introduced the following guests and asked each to come to the podium to address the House: Mrs. Ebba Dunn, President-elect, Southern Medical Association Auxiliary and Mrs. Charles Rodgers, President, Arkansas Medical Society Auxiliary.

Dr. Payton Kolb, Delegate to the AMA, introduced Dr. Joseph T. Painter, Chairman of the Board of Directors of the AMA, Houston, Texas. Dr. Painter addressed the House. At the conclusion of Dr. Painter's speech, he was presented with an Arkansas Traveler's Certificate.

Speeches from the House of Delegates appear throughout *The Journal*.

Speaker Crenshaw announced there were 98 voting members in attendance.

Upon a motion the House approved the minutes of the 115th annual session as printed in the June 1991 issue of The Journal of the Arkansas Medical Society.

Speaker Crenshaw asked Peggy Pryor Cryer, Executive Secretary of the Arkansas State Medical Board, to come to the podium. Ms. Cryer addressed the House and then asked Dr. Ray Jouett, Chairman of the Board of Directors of the Arkansas State Medical Board, to come to the podium. Dr. Jouett presented a plaque to Dr. Joe Verser for his 42 years of service as Secretary to the Arkansas State Medical Board. Dr. Ray Jouett also presented plaques to Dr. Jim Lytle and Dr. James Gardner for their service on the Arkansas State Medical Board. (Dr. Gardner was not in attendance.)

Dr. George Warren and Dr. Charles Logan made presentations to Dr. Cal Sanders and Dr. Jim Lytle, each who had served as an AMS Councilor for ten years (Dr. Cal Sanders was not in attendance.) Plaques of appreciation were also presented to Dr. James Kolb, Treasurer of the AMS for eleven years of service; Dr. John Bell, AMS Councilor for nineteen years; and Dr. L. J. Pat Bell, AMS Councilor for twenty-eight years.

Dr. George Warren asked Mrs. Rita Rodgers, President of the Arkansas Medical Society Auxiliary, Mrs. Sandy Finkbeiner, State Chairman of the AMA Auxiliary Education and Research Foundation (AMA-ERF), and Dr. I. Dodd Wilson, Dean of the University of Arkansas College of Medicine, to come forward for the presentation of the AMA-ERF checks. Checks were presented to Dr. Wilson in the amounts of $3,837.59 for pursuit of excellence in the medical schools' program with no restrictions on the use of the money and $26,852.36 restricted to the schools' program of financial assistance for medical students.

Speaker Crenshaw asked Dr. Joe Martindale to the podium to update the House on the Physician's Health Committee activities. Speaker Crenshaw also asked Dr. William Jones to come forward and explain the petition drive for the tobacco tax.

Speaker Crenshaw listed the items of business received by the society office at least twenty days prior to the meeting but not published in the Journal. These items are as follows: a resolution to establish a separation of peer review activity from the policy making body of the Arkansas Medical Society submitted by the Garland County Medical Society; a resolution in support of school-based clinics submitted by the Washington County Medical Society; and a resolution calling for the establishment of a UAMS scholarship program submitted by the Washington County Medical Society. Each item was assigned to a reference committee and was included in the delegates packets.

Speaker Crenshaw announced the following vacancy on the Arkansas State Medical Board and reminded the members from the counties in the district to meet following the adjournment to vote for three con-

gressional nominees. The vacancy is in the Fourth Congressional District. George Wynne of Warren is currently serving and his term will expire in December 1992. Dr. Wynne is eligible to succeed himself.

Counties in the Fourth Congressional District include Ashley, Bradley, Calhoun, Clark, Columbia, Hempstead, Howard, Little River, Lafayette, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier, and Union.

Speaker Crenshaw also announced the vacancies on the Arkansas State Board of Health and asked members from the counties in the district to meet and vote for three congressional nominees. Vacancies on the State Board of Health will occur December 31, 1992, in the First and Fifth Congressional District positions.

Dr. Don B. Vollman, Jr. of Jonesboro is currently serving in the First Congressional District and is eligible to succeed himself. Counties in the First Congressional District include Clay, Craighead, Crittenden, Cross, Greene, Lee, Mississippi, Phillips, Poinsett, and St. Francis.

Dr. James Maupin of Dardanelle is currently serving in the Fifth Congressional District and is eligible to succeed himself. Counties in the Fifth Congressional District include Conway, Faulkner, Perry, Pope, Pulaski, and Yell.

Speaker Crenshaw announced the 1992-93 Nominating Committee members as follows: District #1, Dr. Richard O. Martin, Paragould; District #2, Dr. Michael N. Moody, Salem; District #3, Dr. Samuel A. McGuire, Forrest City; District #4, Dr. Lee A. Forestiere, Pine Bluff; District #5, Dr. Wayne G. Elliott, El Dorado; District #6, Dr. Herbert B. Wren, Texarkana; District #7, Dr. Thomas H. Hollis, Hot Springs; District #8, Dr. Harold Purdy, Little Rock; District #9, Dr. David L. Rogers, Fayetteville; and District #10, Dr. William W. Galloway, Russellville.

Speaker Crenshaw reminded the House of the Reference Committee meetings to be held Friday morning.

After announcements the meeting adjourned until Saturday, April 11th.

Late Resolutions

Resolution from the Garland County Medical Society to Establish a Separation of Peer Review Activity from the Policy Making Body of the Arkansas Medical Society

Whereas, the Arkansas Medical Society is the organization which represents the whole of the state's physicians in medical, economic and political matters, and

Whereas, the Arkansas Medical Society executive committee is elected to direct policy of the Arkansas Medical Society and to represent the physicians of the state of Arkansas as advocate, and

Whereas, peer review activity may place the reviewing body of physicians in an adversarial position to the physicians of the state of Arkansas, and

Whereas, the function of peer review should be encouraged by the Arkansas Medical Society and performed by physicians independent of the executive and/or policy making body of the Arkansas Medical Society, therefore be it

Resolved, that to avoid a conflict between the executive body of the Arkansas Medical Society in their advocate role, a policy shall be established that members of the Arkansas Medical Society executive body shall not participate in peer review activity except on the local level, and be it further

Resolved, that the function of peer review activity shall be encouraged and performed by physicians independent of the policy making and/or executive body of the Arkansas Medical Society, and that these physicians be selected through a committee process approved by the members of the Arkansas Medical Society.

Resolution from the Washington County Medical Society in Support of School-based Health Clinics

Whereas, almost one-fourth of the children in Arkansas live below the poverty level and Arkansas children suffer from health problems including dental cavities, obesity, congenital abnormalities, lack of immunizations, drug and alcohol abuse, pregnancy and psychosocial problems, and

Whereas, children are Arkansas' most important assets, yet many arrive at school in poor health which

makes it difficult for them to learn and more frustrating for teachers to try to instruct them, and

Whereas, children who live in rural areas or inner cities, who live in poverty or are uninsured or underinsured have little or no access to basic medical care, and

Whereas, single parent families or homes with two working parents make up the majority of the households today, and often parents have difficulty taking off work to take a child to a doctor as they cannot afford the loss of income or fear for loss of their job, and

Whereas, school-based health clinics make health care accessible, affordable and efficient by stressing prevention and healthy lifestyles, catching serious illnesses early, providing health counseling, and treatment of minor illnesses which left unattended could progress to serious problems, and referral for more intensive care to medical offices in a timely and appropriate fashion, and

Whereas, a wide range of services can be made available through school-based health clinics, but clinics are only established at the request of a school board and parental consent must be obtained in order to provide care to children, therefore be it

Resolved, that the Washington County Medical Society strongly endorses the use of school-based health clinics in our county and throughout the state of Arkansas, and be it further

Resolved, that this resolution be brought before the Arkansas Medical Society with a strong recommendation that it be adopted by the State Society.

The Changing World of Medicine

116th Annual Session
Arkansas Medical Society
Excelsior Hotel, Little Rock
April 9-11, 1992

Physicians	361
Spouses	124
Guests	50
Exhibitors	224
AIDS Seminar	124
Total attendance	**883**

Resolution from the Washington County Medical Society Calling for the Establishment of a UAMS Scholarship Program

Whereas, we as physicians have experienced the difficulties of financing medical education for ourselves and our children, and

Whereas, we realize the inherent stresses placed on students, their spouses and families, and

Whereas, we are aware of the rising cost of medical education with representative graduation debts of upwards to $100,000 dollars, and that the debt load has been associated with influencing the career paths graduates take, and

Whereas, we recognize the interest of the UAMS College of Medicine to secure scholarship support for all our needy students, therefore be it

Resolved, that the Washington County Medical Society urges each county society and the Arkansas Medical Society to unite in a coordinated effort to establish a scholarship program to aid Arkansas students attending UAMS, and be it further

Resolved, that an Ad Hoc Committee be formed to aid in establishing this program and develop guidelines for its support and administration.

Joint venture financial partners sought to build pre-sold, affordable houses throughout Arkansas. Unique opportunity with high return on your investment. Call today for more information.
Jim Collins, President

(501) 224-2212 or 1-800-662-1633

House of Delegates
Final Session - April 11, 1992

Speaker Crenshaw called the meeting to order and asked Nominating Committee Chairman Charles Logan to present the revised Nominating Committee report. Dr. Logan read the following slate of officers:

President-elect:
Glen F. Baker, M.D., Little Rock
Vice President:
Steve Schoettle, M.D., West Memphis
Treasurer:
Lloyd G. Langston, M.D., Pine Bluff
Secretary:
Charles H. Rodgers, M.D., Little Rock
Speaker of the House of Delegates:
John Crenshaw, M.D., Pine Bluff
Vice Speaker of the House of Delegates:
vacant
Councilors:
District #1:
Dwight Williams, M.D., Paragould
District #2:
Michael N. Moody, M.D., Salem
District #3:
Samuel A. McGuire III, M.D., Forrest City
District #4:
Paul A. Wallick, Monticello
Anna T. Ridling, Pine Bluff
District #5:
Robert H. Nunnally, M.D., Camden
District #6:
James D. Armstrong, M.D., Ashdown
District #7:
Ronald J. Bracken, M.D., Hot Springs
District #8:
David L. Barclay, M.D., Little Rock
R. Jerry Mann, M.D., Little Rock
Harold D. Purdy, M.D., Little Rock
District #9:
Robert H. Langston, M.D., Harrison
Janet Titus, M.D., Winslow
District #10:
Morton C. Wilson, M.D., Fort Smith
Gerald A. Stolz, M.D., Russellville

Delegates to the AMA (Term 1/1/93 to 12/31/94):
John P. Burge, M.D., Lake Village
Asa A. Crow, M.D., Paragould

Alternate Delegates to the AMA (Term 1/1/93 to 12/31/94):
John M. Hestir, M.D., DeWitt
William N. Jones, M.D., Little Rock
David L. Rogers, M.D., Fayetteville

Dr. Glen Baker was elected president-elect by acclamation as were the other nominees. Dr. Baker addressed the House.

Speaker Crenshaw asked President George Warren to come forward to addresss the delegates and members. Dr. Warren asked Mr. Lynn Zeno and Mr. David Wroten of the AMS staff to address the House on the accomplishments of the Medical Society in the past year.

The next order of business was the reports from the Reference Committees.

SOUTHEAST - GENERAL SURGERY

Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice with coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician $150,000 net before taxes for 2 years.

Call Richard Glehan at 1-800-221-4762

1992-1993 OFFICERS

J. Larry Lawson, Paragould, President
Glen Baker, Little Rock, President-elect
Steve Schoettle, West Memphis, Vice President
George Warren, Smackover, Immediate Past President
Charles Logan, Little Rock, Chairman of the Council
Charles Rodgers, Little Rock, Secretary
Lloyd Langston, Pine Bluff, Treasurer
John Crenshaw, Pine Bluff, Speaker of the House
Vice Speaker - vacant

EXECUTIVE COMMITTEE

Charles Logan, Little Rock, Chairman of the Council
J. Larry Lawson, Paragould, President
Glen Baker, Little Rock, President-elect
Charles Rodgers, Little Rock, Secretary
Lloyd Langston, Pine Bluff, Treasurer
George Warren, Smackover, Immediate Past President

COUNCILORS AND COUNCILOR DISTRICTS

FIRST DISTRICT

Merrill Osborne, Blytheville (1993); Dwight Williams, Paragould (1994); Clay, Craighead, Crittenden, Greene, Lawrence, Mississippi, Poinsett, and Randolph

SECOND DISTRICT

Lloyd Bess, Batesville (1993); Michael Moody, Salem (1994); Cleburne, Conway, Faulkner, Fulton, Independence, Izark, Jackson, Sharp, Stone, and White

THIRD DISTRICT

Hoy Speer, Stuttgart (1993); Samuel McGuire, Forrest City (1994); Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis, and Woodruff

FOURTH DISTRICT

Anna T. Ridling, Pine Bluff (1993); Paul Wallick, Monticello (1994); Ashley, Chicot, Desha, Drew, Jefferson, and Lincoln

FIFTH DISTRICT

Wayne Elliott, El Dorado (1993); Robert Nunnally, Camden (1994); Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita, and Union

SIXTH DISTRICT

F. E. Joyce, Texarkana (1993); James Armstrong, Ashdown (1994); Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk, and Sevier

SEVENTH DISTRICT

Thomas Hollis, Hot Springs (1993); Ronald Bracken, Hot Springs (1994); Clark, Garland, Grant, Hot Spring, Montgomery, and Saline

EIGHTH DISTRICT

Paul Cornell, Little Rock (1993); Charles Logan, Little Rock (1993); Robert Shannon, Little Rock (1993); David Barclay, Little Rock (1994); R. Jerry Mann, Little Rock (1994); Harold Purdy, Little Rock (1994); vacancy, term will expire 1993; Pulaski

NINTH DISTRICT

David Rogers, Fayetteville (1993); Robert Langston, Harrison (1994); Janet Titus, Winslow (1994); Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren, and Washington

TENTH DISTRICT

Paul Wills, Fort Smith (1993); Gerald Stolz, Russellville (1994); Morton C. Wilson, Fort Smith (1994); Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian, and Yell

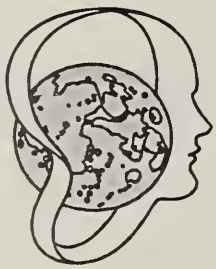
Reference Committee #1

Marvin Leibovich, M.D., Little Rock, Chairman
Simmie Armstrong, M.D., Pine Bluff
William McKiever, M.D., Monticello
Joseph Robbins, M.D., Texarkana
Ms. Debbie Quade, Medical Student Observer

Resolution from the Garland County Medical Society to Establish a Separation of Peer Review Activity from the Policy Making Body of the Arkansas Medical Society

Reference Committee #1 recommends that this resolution not be adopted. There was overwhelming testimony in favor of not adopting this resolution. It was felt that the current peer review activity has functioned fairly and that the proposed resolution would eliminate current medical society leadership, members of the Council and House of Delegates from having the opportunity to participate in Medicaid peer review.

HOUSE ACTION: **REJECTED**



Reference Committee #1 recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* **be filed for information:**

AMS/ABA Task Force on Drug and Alcohol Abuse, Marvin Leibovich, M.D., Chairman
Report of the Council, Charles Logan, M.D., Chairman
Committee on Position Papers, James M. Kolb Jr., M.D., Chairman
Medical Services Review Committee, John Crenshaw, M.D., Chairman
Pension Plan Trustees, Joe H. Stallings Jr., M.D., Chairman
Budget Committee Report, Merrill J. Osborne, M.D., Chairman
Report on the Articles of Incorporation, Ken LaMastus, Executive Vice President

HOUSE ACTION: **FILED FOR INFORMATION**

Report of the Governmental Affairs Committee
Charles Rodgers, M.D., Chairman

Arkansas Medical Society members should be informed that hospitals may now be used to dispose of medical waste for those physicians serving on their respective hospital medical staffs. Reference Committee #1 takes note of the excellent work by Dr. Rodgers, members of the Governmental Affairs Council, and Mr. Lynn Zeno and encourages the House of Delegates to give their most serious consideration to contributing to MED-PAC.

HOUSE ACTION: **FILED FOR INFORMATION**

Physicians' Health Committee
Joe L. Martindale, M.D., Chairman

Reference Committee #1 noted that efforts should be made to work with individuals and possibly the Arkansas Hospital Association to solicit contributions in support of the Physicians' Health Committee as this committee will then be available to members of their respective medical staffs. The committee wishes to express our sincere appreciation to Dr. Martindale for his many hours of unselfish devotion to this effort.

HOUSE ACTION: **FILED FOR INFORMATION**

Report of the Executive Vice President
Mr. Ken LaMastus

Reference Committee #1 requests that the meeting dates of the Nominating Committee, the offices and positions vacant or available, and the names of the members of the Nominating Committee be published in the Arkansas Medical Society Newsletter 30 days prior to each meeting of the Nominating Committee.

HOUSE ACTION: **FILED FOR INFORMATION**

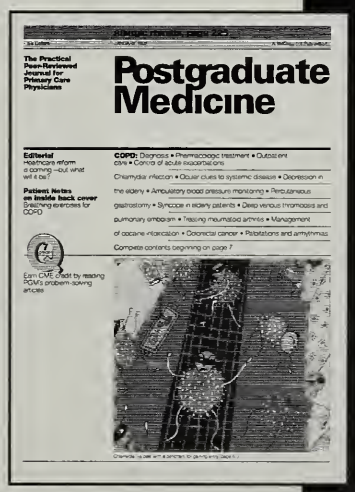
ORTHOPAEDIC RESEARCH AND EDUCATION FOUNDATION

The members of the Order of Merit set the example for their colleagues, orthopaedic industry and the public. They demonstrate the power of philantrhopy in expanding knowledge in orthopaedics for the relief of human suffering. Following is the Arkansas Roster of the 1991 Members, including all orthopaedists from Pine Bluff which has, thereby, been designated a "City of Merit."

- Banks Blackwell, M.D., Medical Director -

James A. Arnold, M.D., Fayetteville
Mr. Michael M. Bailey, Little Rock
Banks Blackwell, M.D., Pine Bluff
(A Memorial Tribute to Lyman Smith, M.D.)
Charles A. Clark, M.D., Pine Bluff
Robert R. Gullett, Jr., M.D., Pine Bluff
(A Memorial Tribute to Richard LeBlanc, M.D.)
Dr. & Mrs. Peter J. Irwin, Fort Smith
Philip H. Johnson, M.D., Little Rock
Dr. & Mrs. James M. Kolb, Jr., Russellville
Dr. & Mrs. Charles A. Ledbetter, Harrison
(A Tribute to Donald B. Kettelkamp, M.D.)
John O. Lytle, M.D., Pine Bluff
Dr. & Mrs. Bruce L. Smith, Jr., Hot Springs
J. L. Vander Schilden, M.D., Little Rock
(A Memorial Tribute to Richard Webber, Ph.D.)

US THEM



WHEN YOU NEED TIME ON YOUR SIDE, THE CHOICE IS CLEAR.

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Postgraduate Medicine

Reference Committee #2

Joe V. Jones, M.D., Blytheville, Chairman
Jim Acklin, M.D., Fort Smith
George Collier, M.D., Paragould
David Jacks, M.D., Pine Bluff

Resolution from the Washington County Medical Society in Support of School-Based Health Clinics

Whereas, almost one-fourth of the children in Arkansas live below the poverty level and Arkansas children suffer from health problems including dental cavities, obesity, congenital abnormalities, lack of immunizations, drug and alcohol abuse, pregnancy and psychosocial problems, and

Whereas, children are Arkansas' most important assets, yet many arrive at school in poor health which makes it difficult for them to learn and more frustrating for teachers to try to instruct them, and

Whereas, children who live in rural areas or inner cities, who live in poverty or are uninsured or underinsured have little or no access to basic medical care, and

Whereas, single parent families or homes with two working parents make up the majority of the households today, and often parents have difficulty taking off work to take a child to a doctor as they cannot afford the loss of income or fear for loss of their job, and

Whereas, school-based health clinics make health care accessible, affordable and efficient by stressing prevention and healthy lifestyles, catching serious illnesses early, providing health counseling, and treatment of minor illnesses which left unattended could progress to serious problems, and referral for more intensive care to medical offices in a timely and appropriate fashion, and

Whereas, a wide range of services can be made available through school-based health clinics, but clinics are only established at the request of a school board and parental consent must be obtained in order to provide care to children, therefore be it

Resolved, that the Arkansas Medical Society endorses the use of school-based health clinics as currently implemented by the Arkansas Department of Health, and be it further

Resolved, that the Arkansas Medical Society urges all physicians, individually and through their county medical societies, to become more involved in their county health departments especially in regard to Arkansas Department of Health school-based health clinics.

COMMENTS: Reference Committee #2 wants to emphasize that the resolution is in-support of school-based health clinics as a function of the Arkansas Department of Health as they "currently" exist, including appropriate medical supervision of the program and any specific treatment rendered.

Reference Committee #2 recommends the adoption of the following substitute resolution:

Resolved, that the Arkansas Medical Society endorses the use of school-based health clinics as currently implemented by the Arkansas Department of Health, and be it further

Resolved, that the Arkansas Medical Society urges all physicians, individually and through their county medical societies, to become more involved in their county health departments especially in regard to Arkansas Department of Health school-based health clinics.

Reference Committee #1 recommends that the resolution be adopted.

HOUSE ACTION: **ADOPTED AS RECOMMENDED**

Resolution from the Washington County Medical Society Calling for the Establishment of a UAMS Scholarship Program

Whereas, we as physicians have experienced the difficulties of financing medical education for ourselves and our children, and

Whereas, we realize the inherent stresses placed on students, their spouses and families, and

Whereas, we are aware of the rising cost of medical education with representative graduation debts of upwards to $100,000 dollars, and that the debt load has been associated with influencing the career paths graduates take, and

Whereas, we recognize the interest of the UAMS College of Medicine to secure scholarship support for all our needy students, therefore be it

COMMENTS: Reference Committee #2 recommends the adoption of the following substitute resolution:

Resolved, that the Arkansas Medical Society and the county medical societies work to unite in a coordinated effort to establish a scholarship program to aid Arkansas students attending UAMS, and be it further

Resolved, that an Ad Hoc Committee be appointed by the Arkansas Medical Society Council to determine the feasibility of implementing this program, develop guidelines for its support and administration, and report its findings to the Council before the fall 1992 meeting.

Reference Committee #1 recommends that the resolution be adopted.

HOUSE ACTION: **ADOPTED AS RECOMMENDED**

Reference Committee #2 recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* **be filed for information:**

Annual Session, Glen Baker, M.D., Chairman
Task Force on AIDS, Joseph Beck II, M.D., Chairman
Medical Student Section, Ms. Katherine Henry, President
Young Physicians Committee, David Harshfield, M.D., Chairman
Independence County Medical Society, Russell Webster, M.D., President
Pulaski County Medical Society, Ashley Ross, M.D., President
Arkansas Health Care Access Foundation, Ray Jouett, M.D., Chairman
Arkansas State Medical Board, Ms. Peggy Pryor Cryer, Executive Secretary
Arkansas Department of Health, Joycelyn Elders, M.D., Director
University of Arkansas College of Medicine, I. Dodd Wilson, M.D., Dean
Medical Education Foundation for Arkansas, Martin Eisele, M.D., President

HOUSE ACTION: **FILED FOR INFORMATION**

Speaker Crenshaw asked Chairman of the Council, Charles Logan, to give the report of the Council which met daily during the meeting.

A Special Thank You

A big thank you to all the following county auxiliaries and individuals who donated baskets to the AMA-ERF Silent Auction held at the Blue Cross and Blue Shield Reception during the 116th Annual Session:

Bowie/Miller County Medical Society Auxiliary
Craighead/Poinsett County Medical Society Auxiliary
Crittenden County Medical Society Auxiliary
Garland County Medical Society Auxiliary
Greene/Clay County Medical Society Auxiliary
Independence County Medical Society Auxiliary
Jefferson County Medical Society Auxiliary
Phillips County Medical Society Auxiliary
Pope County Medical Society Auxiliary
Pulaski County Medical Society Auxiliary
Sebastian County Medical Society Auxiliary
Washington County Medical Society Auxiliary
Mr. & Mrs. Don Bransgaard
Dr. & Mrs. Charles H. Rodgers
Dr. & Mrs. Robert Power

We raised $1525.00! Thanks to everyone.

Mrs. Sandy Finkbeiner
Arkansas Medical Society Auxiliary
AMA-ERF Chairman

The Changing World of Medicine

Audio Tapes Available

Audio casette tapes of the 1992 annual session featured sessions are now available. To order your copies, complete the order form below and send your payment for each tape requested to the Arkansas Medical Society, P. O. Box 5776, Little Rock, Arkansas 72215.

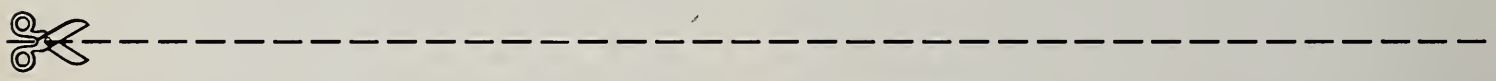
Session summaries are as follows:

"Is There a Certified Rural Health Clinic in Your Future?"
Penny Washington, Reimbursement Specialist for the North Carolina Office of Rural Health and Resource Development, examines the issue of rural health clinics.

"An Agenda for Solving American's Health Care Crisis"
John C. Goodman, Ph.D., President of the National Center for Policy Analysis in Dallas, Texas, was the keynote speaker for the Shuffield Luncheon. He offers solutions for solving the health care crisis.

"Implications of RBRVS: A Panel Discussion"
A panel discussion on the implications of RBRVS. The panel included Joseph T. Painter, M.D., Chairman of the Board of Trustees of the American Medical Association; James N. Haug, Director of the Socioeconomic Affairs Department, American College of Surgeons; James R. Weber, M.D., AAFP representative to the RBRVS study for physician reimbursement.

"HIV Management"
Brady Allen, M.D., a physician in private practice and an associate clinical professor at Baylor University Medical Center in Dallas, Texas, speaks on HIV management. His presentation includes Retrovir therapy, combination therapy with Didanosine, and other newer drugs. A panel of Arkansas physicians joined Dr. Allen for questions and answers.



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"Implications of RBRVS: A Panel Discussion"	$9.75	_____
"HIV Management"	$18.00	_____
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Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.*†

ONCE-A-DAY ‡

ACCUPRIL®™

quinapril HCl tablets 10, 20, 40 mg

* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

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PARKE-DAVIS

USE IN PREGNANCY
When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, ACCUPRIL should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE
ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS
ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS
Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of ACCUPRIL as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, ACCUPRIL should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. Removal of ACCUPRIL, which crosses the placenta, from the neonatal circulation is not significantly accelerated by these means.

No teratogenic effects of ACCUPRIL were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 180 times (in rats) and one time (in rabbits) the maximum recommended human dose.

PRECAUTIONS
General
Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent, and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients
Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions
Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:
- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro chromosome* aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy
Pregnancy Categories C (first trimester) and D (second and third trimesters): See WARNINGS, Fetal/Neonatal Morbidity and Mortality

Nursing Mothers
It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use
Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use
The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS
ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuance)	Placebo (N = 579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

See PRECAUTIONS, Cough.

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Fetal/Neonatal Morbidity and Mortality
See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings
Hematology: (See WARNINGS)
Hyperkalemia: (See PRECAUTIONS)
Creatinine and blood urea nitrogen: Increases (↑1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

*In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

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Report of the Council

Charles Logan, M.D., Chairman

The Council met on Thursday, April 9, at the Excelsior Hotel in Little Rock. The following business was received and transacted:

1. The Council approved the minutes of the following meeting: the February 9th Council meeting; the February 26th and March 25th Executive Committee meetings.
2. Dr. Joseph T. Painter, Chairman of the Board of Trustees of the American Medical Association, briefly addressed the Council.
3. The following reports were accepted for information: 1991 Arkansas Medical Society Audit and the Budget and Membership Reports for the period ending February 28, 1992.
4. Dr. William Jones explained the goals of the Coalition for a Healthier Arkansas (CHAR) and the proposed Tobacco Tax and Health Act. Upon motion of the Council he recommended that the Budget Committee immediately give $20,000 to CHAR and to plan for additional contributions in the range of $15,000 to $20,000 when the tobacco companies and tobacco institute begin their campaigns against CHAR. This was approved by the Council.
5. Dr. Charles Rodgers, chairman of the Governmental Affairs Council, gave an update of their activities. He urged the councilors to review their legislative handbooks and urged everyone to contribute to MED-PAC.
6. Mr. David Wroten informed the Council of the work being done with the State Chamber of Commerce regarding the Workers' Compensation Fee Schedule.
7. Upon motion, the Council approved the request for dues exemptions for life, emeritus, and affiliate memberships for the following members:

Life Membership - James W. Marsh, Bradley; J. Warren Murry, Cleburne County; Millard C. Edds, Crawford County; Glenn P. Schoettle, Crittenden County; Bedford W. Smith, Crittenden County; Guy U. Robinson, Desha County; Arlee K. Busby, Drew County; W. Martin Eisele, Garland County; A. Dale Gullett, Howard-Pike County; Ralph F. Joseph, Lawrence County; Fred C. Inman, Jr., Lonoke County; Benedict F. Pupsta, Monroe County; David M. Williams, Pope County; John C. Baber, Jr., Pulaski County; H. A. Ted Bailey, Jr., Pulaski County; Joseph D. Calhoun, Pulaski County; A. Stuart Fitzhugh, Pulaski County; John M. Fulmer, Pulaski County; W. Wayne Workman, Pulaski County; Robert J. Thompson, Sebastian County; A. Meryl Grasse, Tri-County; C. E. Tommey, Union County; C. Stanley Applegate, Washington County; and Jack A. Wood, Washington County.

Emeritus Membership - Eugene H. Ball, Benton County; Paul L. Mohoney, Jr., Boone County; Sidney W. Arnold, Crittenden County; Joseph Ward, Pulaski County; G. Doyne Williams, Pulaski County; William C. Culp, Sebastian County; James M. Post, Sebastian County; and Spencer Albright, III, Washington County.

Affiliate Membership - Helga E. Chock, Baxter County; John W. Jacks, Benton County; Robert E. Burns, Drew County; Norman W. Peacock, Little River County; William J. Roberts, Logan County; C. Yulan Washsburn, Lonoke County; E. A. Shaneyfelt, Mississippi County; R. Lee Austin, Pulaski County; Donald G. Browning, Pulaski County; Guy R. Farris, Jr., Pulaski County; George M. Goza, Jr., Pulaski County; J. Harry Hayes, Jr., Pulaski County; Ben O. Price, Pulaski County; E. Clinton Texter, Pulaski County; Neil E. Crow, Sr., Sebastian County; Joseph H. McAlister, Washington County; and Henry C. Farrar, White County.

8. The Council was reminded of the Arkansas Foundation for Medical Care membership meeting to be held at the Capitol Hotel at 9:00 a.m. Sunday. A brief report from the Foundation chairman, Dr. James Armstrong, was presented.
9. Dr. Ronald Bracken explained the resolution from the Garland County Medical Society which has been referred to a reference committee.
10. Dr. Joseph Beck, chairman of the Committee on AIDS, presented a plan to assist HIV positive health care workers in dealing with their condition. Upon motion the Council voted to consider a statewide

health committee for health care workers who are infected with the HIV at the next Council meeting.

11. Mr. Mike Mitchell, the Society's Legal Counsel, presented a resolution to amend the Arkansas Medical Society Purchase Pension Plan and Trust which would allow the AMS Benefits, Inc. employees to participate in the pension plan. This was enacted.
12. Dr. Glen Baker, chairman of the Annual Session Committee, presented the dates for the AMS annual session for the years 1997, 1998, 1999, and 2000. The dates and locations are May 1-4, 1997 - Arlington Hotel, Hot Springs; April 2-4, 1998 - Excelsior Hotel, Little Rock; April 29-May 1, 1999 - Arlington Hotel, Hot Springs; and March 30-April 1, 2000 - Excelsior Hotel, Hot Springs.
13. Dr. George Warren gave an update on MED-PAC and Presidential Program and urged everyone to contribute.
14. Mr. Ken LaMastus and Mr. Jim Irwin of Irwin Company discussed the status of negotiations with Berkshire Life Insurance Company to purchase the AMS building. Mr. Mike Mitchell explained the liability of Flake and Company concerning the mortgage, land, and building. Jim Irwin presented a recommendation to buy the building by assuming a non-recourse loan with zero equity and at a reduced interest rate. He explained the advantages and disadvantages of this approach. After a long discussion and upon motion the Council voted to proceed with Mr. Irwin's recommendation.
15. The following Council committee appointments were approved:
    a. Medical Services Review Committee:
       Allergy: Martin Fiser, Little Rock
       Dermatology: Scott Dinehart, Little Rock (pending AMS membership)
       Ophthalmology: Stephen K. Magie, Conway
       Otolaryngology: Jim English, Little Rock
       Radiology: John W. Joyce, Little Rock
       General Surgery: Robert Tommey, El Dorado
       Neurosurgery: David Reding, Little Rock
       Pediatrics: Anthony Johnson, Little Rock
    b. Medical Services Review Committee Subspecialties:
       Emergency Medicine: William G. McDonald, Little Rock
       Cardiovascular Surgery: William Fiser, Little Rock
       Gastroenterology: John T. Baber, Little Rock
       Nephrology: James A. Wellons, Little Rock
       Oral Surgery: Robert Anderson, Little Rock
       Pediatric Allergy: Fred Kittler, Little Rock
       Plastic Surgery: Luther Walley, Hot Springs
       Pulmonary Disorders: John C. Schultz, Little Rock
       Thoracic surgery: Leon P. Woods, Fort Smith.
    c. Pension Plan Trustees: Robert Langston, Harrison and William Rutledge, Little Rock.
    d. Medical Education Foundation for Arkansas: Martin Eisele, Hot Springs.
    e. Committee on Position Papers: Dennis Jacks, Pine Bluff; J. David Busby, Alma; Jim English, Little Rock; and Lee Forestiere, Pine Bluff.
    f. Budget Committee: Jerry Mann, Little Rock and Dwight Williams, Paragould (filling the un-expired term of Thomas Hollis).
    g. Young Physicians' Committee:
       District #3, Robert Hayes, Wynne
       District #7, Timothy English, Hot Springs
       District #9, T. Patrick Coker, Fayetteville (pending AMS membership)
       District #10, Michael Bell, Russellville.

16. Dr. Walt Morrison of the School of Pharmacy explained the recently implemented Arkansas Medicaid Prior Authorization Drug Program and answered questions for the Council.
17. Mr. Ken LaMastus presented a resolution from the AMA for state and local societies to comply with the Federal Trade Commission order. The Council voted and adopted this resolution.
18. Dr. James Kolb updated the Council on negotiations with the State Chamber of Commerce in regard to the workers' compensation fee schedule. The Council voted for the committee to continue to negotiate the Blue Cross Blue Shield fee schedule or one similar. Dr. William White of Blue Cross Blue Shield explained their fee schedule and how it would affect physicians.
19. Dr. Wayne Elliott, chairman of the Budget Committee, gave a report of the Budget Committee which had met and agreed to contribute $20,000 to CHAR as had been recommended earlier in the Council meetings. Upon motion the Council voted in favor of this contribution. Dr. Jones will make this contribution to them next week.

Speaker Crenshaw announced the following State Medical Board nominees:

Fourth Congressional District of the Arkansas State Medical Board: Curtis Ripley, Crossett; Cal Sanders, Camden; and Wayne Elliott, El Dorado.

First Congressional District: George Collier, Paragould; Don B. Vollman, Jonesboro; and Dwight Williams, Paragould.

Fifth Congressional District: James Maupin, Dardanelle; James Kolb, Russellville; and Raymond Biondo, North Little Rock.

Speaker Crenshaw announced the 1992-1993 Nominating Committee officers: Michael Moody, Salem, Chairman, and David Rogers, Fayetteville, Secretary.

Speaker Crenshaw announced the Arkansas Foundation for Medical Care meeting on Sunday morning at the Capitol Hotel. He also encouraged support of MED-PAC and other involvement in political activities.

There being no further business, the meeting adjourned.

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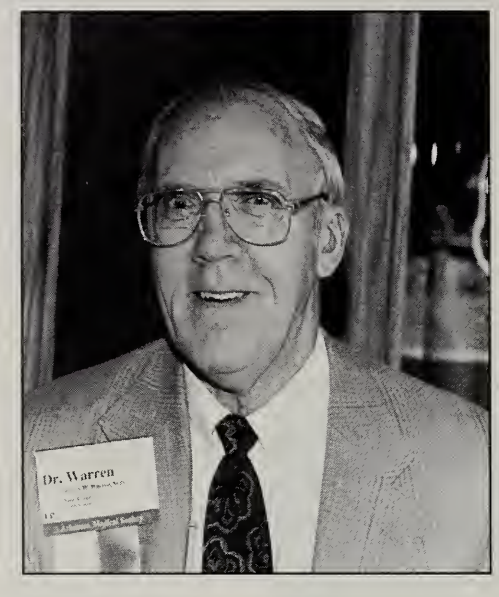
AIR FORCE

Address by George W. Warren, M.D.

1992-1992 President



In high school, I took two years of Latin. At that time, a required subject for any student contemplating a career in medicine. Latin was the greatest course I took in high school to help me in English. One phrase I still remember from Latin is tempus fugit. For me that phrase, tempus fugit, time flies, truly represents my year as President of the Arkansas Medical Society.

My year began with many expectations of an exciting and productive year. One of my early desires was to have all past presidents and current officers be members of the President's Club. For those who may not know what that means, it means making a $200 contribution to the Governmental Affairs Committee. I reasoned that past officers having knowledge of the true value of the governmental affairs division and current officers knowing the many problems besetting medicine today and being aware of the work of Lynn Zeno and what had been accomplished in the 1991 legislative session, there would be no hesitancy in all paying $200 to keep the ball rolling. I learned that high ideals and forth coming dollars do not always coincide.

I thank all who did join the President's Club. Our need has never been greater, our present and upcoming challenges at times seem insurmountable. What our chances of success are, however will depend upon our governmental affairs division having the funds necessary to act decisively and timely.

Again, I make a plea for all past and present officers and our general membership to help fund our governmental affairs division.

Several months ago, I determined that I would not make a long President's report but would instead involve two very important members of our headquarters staff to help present to the House of Delegates information concerning their area of expertise. Lynn Zeno, Director of Governmental Affairs and Assistant Executive Vice President David Wroten, who has been intimately involved with our attempt to liaise with the Workmans' Compensation Commission and the development of our for-profit subsidiary. Ken LaMastus has presented his annual report to the Reference Committee, but Lynn and David have no such forum, so I am giving them what I feel is an important opportunity to report to you regarding their two vital functions of our Society. After they have each given their reports, we will have an opportunity for questions and answers.

Address by Mr. Lynn Zeno:

Last year at our annual meeting, we devoted a great deal of attention to the successes we enjoyed at the then, just completed, session of the Arkansas General Assembly. During Dr. Warren's term we anticipated regrouping and preparing for the future in a leisurely fashion so we would be ready for the next legislative session. Little did we know that during Dr. Warren's term there were going to be activities that represented unprecedented changes in the way you practice medicine.

In 1991-92 we saw the implementation of the RBRVS Medicare payment system. This included probably the most drastic changes since the inception of Medicare in the mid 1960's. The changes are primarily the CPT codes with particular emphasis on evaluation and management. This required the Medical Society to conduct 13 statewide seminars in cooperation with Blue Cross Blue Shield. We had 2,500 people attend these seminars.

Also, at a time when we were trying to fight the RBRVS, Washington sent down the safe harbor regulations. For those physicians impacted because they referred patients to an entity in which they had an ownership interest, we had to conduct seminars to inform them of the new regulations.

In addition, often times in the Society there are things going on behind the scenes that, maybe fortunately, never come to your attention. A perfect example is when earlier in the year HCFA announced that they were going to require every physician to pay a fee for the certification of their laboratories. You were going to have to pay that fee and agree to the terms of their contract without ever seeing the regulations. This was proposed in February of last year. The Medical Society's legal counsel, Mike Mitchell, with some assistance from the AMA, prepared litigation and we had motions and a lawsuit ready to file against HCFA alleging that the collection of these fees were unlawful. As a direct threat of our litigation, strictly an Arkansas effort, HCFA withdrew their proposal to collect these fees on the front end. Fortunately this is something the members never had to read about or get involved with.

The Society has been involved in the recent monitoring of OSHA regulations regarding the safety precautions of exposure to bloodborne pathogens. You have received information on how to comply with those regulations. As mentioned in this morning's seminar, we are currently working with the Arkansas Congressional Delegation on national legislation to require HCFA to use current, accurate data, collected in cooperation with state medical societies in determining the geographical practice cost indices. These calculations determine what you are paid under Medicare reimbursement. I think you will see a major announcement by Senator Pryor's office next week.

In addition to this, activity on the state level has been equally intense during Dr. Warren's term in office. You received a legislative handout with your information packet at registration. The Governmental Affairs Council, chaired by Dr. Charles Rodgers, has already determined a variety of issues that will be addressed in the next session of the Arkansas Legislature.

Also, Dr. Bill Dedman of Camden is the chairman of a Perinatal Committee which has worked diligently throughout the year to establish proposed laws that will help ease the problem we have with the shortage of physicians delivering babies in rural parts of Arkansas.

Most of you saw the news conference held at the State Capitol last week. The Arkansas Health Care Access Foundation, which is an entity of the Arkansas Medical Society, where we have 850 volunteer physicians who provide their services free to the medically indigent, announced that Pfizer Pharmaceuticals will be providing all of their drugs free to participants in the program. This culminates months of work toward this admirable goal.

We were successful in the most recent special session of the legislature in attaching some amendments to the medical waste laws. Again, these are things we did not publicize but worked behind the scenes. Those amendments will allow physicians to continue to dispose of their medical waste at those local hospitals that are providing that opportunity. Otherwise you would be forced to go out and contract with a disposal agency at an additional cost.

I think we are very close to a successful conclusion to the proposed Workers' Compensation Fee Schedule. I can assure you that there have been lots of hours, meetings, and educational functions involved with this major regulatory proposal.

And finally, we have just embarked on what is probably going to be the largest public health campaign that the state of Arkansas has ever seen. The AMS has joined the Coalition for a Healthier Arkansas to pass the tobacco tax initiative which will reduce the use of tobacco products; raise much needed funds for services to the medically indigent; educate our youth regarding the dangers of tobacco products; raise money for senior citizen services; and, help fund cancer research projects.

Dr. Warren, you have had a very successful year. We are glad it was during a leap year because if we had not had that extra day we're not sure we could have gotten it all in.

Thank you.

Address by Mr. David Wroten:

A few weeks ago Dr. Warren and I were talking about his year as AMS president. He was really concerned because he did not feel that he had accomplished much. Of course it is because of those accomplishments that Lynn and I are up here. Dr. Warren, the most important duty of the president is to be a leader. The purpose of a leader is to lead, to guide the staff, to give us counsel, to guide the other officers, and to see that we are all doing the things we need to do to move the Medical Society forward. I think you have accomplished that.

When looking back at what has been accomplished over the past year, the best thing to do is to look at the

results. Lynn and I were putting our presentations together in the office and I said, "You know, maybe in my introduction I should touch on the seminars we did on evaluation and management codes, the safe harbor regs, and the RBRVS." Then Lynn said, "Well, that's government stuff so maybe I should talk about that." A few minutes went by. As I was writing I thought about the lawsuit we prepared against HCFA. Even though we never had to file it I thought I should mention it. Lynn said that was a governmental affairs subject, too. My last option was the OSHA publication which we developed and mailed last week. Of course Lynn said that too was governmental affairs business.

I explained to Dr. Warren that Lynn wanted to take credit for most of our accomplishments from the past year. Dr. Warren suggested that I talk about the health insurance plan we developed and our efforts to resolve the workers' compensation problems. Therefore, that is what I will do.

These are two important projects that have taken place over the last year. The first one is the health insurance program which has been developed for you and your clinic staff. Actually, it started about a year and a half ago. Dr. Warren, Dr. Baker, and others were part of a committee that spent a great amount of time researching what other states were doing and what benefits were needed in our clinics.

Last September that research culminated in a survey we mailed to all AMS members and to members of the Medical Group Managers Association. Out of that survey, we determined the interest in this idea was overwhelming. The survey produced very good actuarial numbers as well as some valuable marketing information. The next step was to go to the actuary who computed rates for the plan. Based upon the research, survey, and rating information it became apparent that a partially self-funded plan was both feasible and from a control standpoint, preferable.

In November of 1991, the Council agreed to embark on this project. Since that time we have come a long way. We have formed a non-profit Employee Benefit Trust which collects premiums and pays claims. At the same time we established a for-profit subsidiary to administer the plan while protecting the Society's tax-exempt status. The administration of the health care program is being done in cooperation with the Mississippi State Medical Association who serves as our third-party administrator.

By January 1 we started the marketing program. By February 1 we sold our first policy, brought in our first clinic, and brought in our first employee. Alanna will you please stand? I would like to introduce everyone to Alanna Scheffer. Alanna is the person we have hired to administer all AMS insurance programs. Believe me we are very, very luck to have her.

We were hoping to find someone with medical underwriting experience or claims paying experience and we got both. Alanna has over ten years experience in the field, working mostly with Medicare supplements and individual health plans. Since she came on board things have really been rolling.

Today we have approximately 50 employees enrolled in the program. That may not sound like much but remember, we just started. The hardest problem today is trying to get to all of the people who want us to come see them. We have approximately 150 people who are currently filling out applications or in medical underwriting. I can't tell you how many clinics that represents or the variety of clinics. We are almost over the hump. By the end of the first six months the program should be well on its way. I believe the Medical Society has taken a good step forward in the benefits it provides to its members.

The next issue I would like to discuss is the workers' compensation fee schedule. We have one goal and that is to stop the Workers' Compensation Commission from implementing Proposed Rule 30. Rule 30 would adopt Medicare fees as the fee schedule for workers' compensation. There is no need to talk about the drastic impact this proposal would have on the injured worker's access to needed medical care. It's unbelievable that the Commission would even consider such a thing. In our comments, which I hope each of you have, we were emphatic in telling the Commission that this proposal is irresponsible. They have been told similar statements by legislators, local chambers of commerce, labor groups, and by physicians across the state.

Our involvement with this issue began over a year ago when the AMS recommended a methodology to establish a fair fee schedule. We thought everything was going smoothly until January 20 of this year when the Commission came out with "their" proposal. I will not spend a lot of time explaining the history of this issue. What's important is where we are today and the part all of you have played in getting there.

Our efforts on this issue received more support and involvement from physicians and clinic managers and has created more community involvement between the physicians and local employers than any other issue during my eight years with AMS. Regardless of what happens with the fee schedule, this in and of itself is a success story and will bring benefits down the road that we can only begin to envision right now. Especially if you continue that dialogue with the local industries in your neighborhoods.

The Commission has received nearly 4,000 comments on Proposed Rule 30. The Medical Society received over 200 written comments from physicians and clinics. Over 500 physicians responded to our survey. Eighty-five percent said they could not treat workers' comp injuries if the fees were equal to Medicare.

As you know, we have been involved in negotiations with the State Chamber of Commerce. The Chamber's position has evolved to a point where they would accept Blue Cross rates minus 10%. Obviously we have come a long way from Medicare. The Medical Society's position is and will continue to be that we cannot accept anything less than Blue Cross. Blue Cross has agreed to work with the Commission. At this point we are confident that an agreement will be reached that would establish fees that are approximately equal to Blue Cross Blue Shield.

Dr. Warren, as Lynn has already said, it has not been a boring year. Every year about this time the AMS staff (and you must know we do this) starts wondering what the new president will be like. What's it going to be like working with this person for a year? Well, it has been a pleasure to work with Dr. Warren and I can say that from all of us. We all have a great deal of respect for him and we have enjoyed working with him.

In closing, Dr. Warren has gotten to like us so much that he has asked us to call him by his first name. So we call him Doctor.

Thank you.

Lynn and David, I thank you very much for your participation in this discussion. I hope that the House is now better able to understand the very important functions which the two of you so ably carry on for our Medical Society.

I have enjoyed this opportunity to serve the Arkansas Medical Society. Unfortunately, not all my early expectations were fulfilled. Some unexpected rough spots were encountered. Many of last year's problems will continue to cause us grief and turmoil in the coming months. However, with our excellent headquarters staff, to each of whom I express my utmost gratitude,

and with your excellent new officers, I am certain no effort will be spared to meet each and every challenge.

As I conclude my remarks another Latin phrase comes to mind when Caesar was at his greatest power, he said "We came, we saw, we conquered." I came, I saw, but unfortunately, I see that there is much yet to be conquered.

As immediate past president, I will continue to work to the best of my ability for the good of Arkansas medicine. ■

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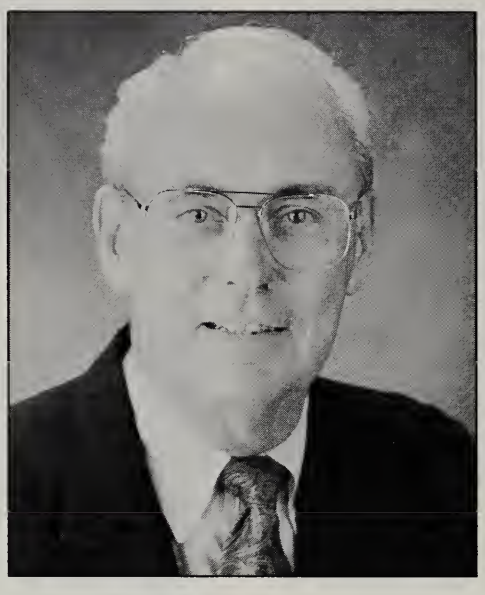

Thank you very much. It always pays to have a good friend to introduce you and I am very appreciative of your remarks. Let me also add that being someone who can't read the sign, at least my forebearers couldn't. I'm delighted to find that Alabama will be facing Arkansas and that we from the University of Texas don't have to come up and get beaten every so often when we think we shouldn't. You have a good team and, of course, a national reputation.

It is fun to be here and to be among so many good friends and to have the opportunity to meet and talk with many of you. I think the one real pleasure one gets on the Board of Trustees is being able to travel around the country to various places attending state meetings and meeting people and listening to what they have to say about the problems in medicine. That helps. That ability to converse with you often gives new ideas and your suggestions often times are quite helpful in shaping a direction in which AMA can move to help the physicians in this country.

Mr. Speaker, let me officially bring greetings to you and this House of Delegates from the American Medical Association and particularly from the AMA Board of Trustees. It's our wish you have a most productive meeting and successful meeting. What you do here is really of major importance. It's important not only to you as the Arkansas Medical Society, but it's important to AMA. Of course many of the things you do here will be dealing with state issues that affect you directly, but only the state of Arkansas. We are very much interested in this because the states now are the ones where health care reform and other measures are being pushed hard as there has been a stalling of the health care reform movement, at least forward progress, at the national level.

Of course many of the issues will also be national—Medicare and all of its problems and the other federal programs that are impacting more and more on each of us every day as we try to practice. Those decisions which you make will be important to the AMA because you can be sure that what policies you create here and then forward to the AMA will be brought to our attention. Not only will George Warren, as your president and as an active person in the AMA, be sure that the message gets delivered but of course you have your AMA delegation. In our House of Delegates they are viewed as a very sound and very good representative group for bringing views forward. You can be sure that A.E. Andrews, John Burge, Payton Kolb, Asa Crow, John Hestir, and David Rogers are all going to be actively pursuing those issues that you think are important that AMA move on.

I would be also remiss if I didn't note that your represented in many other ways. Bill Golden from this state does serve on our Council and Medical Education Committee and is doing an outstanding job. He is one of the leaders who is emerging on that group. Of course Bill Jones whom you know quite well. You may have seen him in action at the AMA as he sought to help shape AMA policy on AIDS and many other things. Certainly his initiative that he has in Arkansas on smoking is one deserving your support.

But I'm also pleased to again see some old friends from Southern Medical. I have the privilege of being on the council representing Texas and serve with John Redmond and David Jacks. John is the current president of the association.

The reason I cite these names is not only to indicate the leaders but the quality of the people that you have leading you and representing you. If you take that group and you multiply it by 49 other states and 87 specialties service and other section representatives, you have a cross section of the talent that is in the AMA House of Delegates representing you and the views of 95% of the physicians of this country. The AMA has a strong team. It has a good board to oversee the implementation is effective. It is becoming stronger and more effective.

Of course the 1990's are already a great challenge. You have only to feel the changes that have emerged since the first of the year since RBRVS and all of the changes you have to go through. But make no doubt about it, our profession is under attack. The regulations and red tape are stifling our ability to practice. We have cost shifting; we have price control; we have second guessing of all our medical decisions; we have the administrative quagmire you have to go through; and even the "May I" phone call that you must make to the local insurer to be sure you can do something before it is done.

But delivering care is getting more difficult and more frustrating for patients and physicians. AMA is taking a different posture because we believe the 90's demands a different organization. No longer can the AMA or any other organization or an individual physician go it alone. What we must do in the 90's is to establish a partnership—a good working relationship between the states and the AMA, that use the collective talents and strengths of each group. And beyond that to the specialty societies and other related groups in the medical system.

More importantly, the AMA has to learn to listen and to hear what is being said from the grass roots and from the state associations. We must build that consensus of viewpoint as to what's best to be done and then reach out to every physician in the country and make sure they know what is being done on their behalf. Beyond that, however, the AMA must lead and act decisively as always. We have got to be willing to take some risks in order to make the gains needed to allow us to deliver care to our patients without the restrictions that are currently being imposed.

No longer, however, can the AMA do everything. The AMA must focus it's activities and prioritize what it does to the really important things that affect practice. And we must fight—but fight smart. We must fight in Congress. We are fighting in the agencies when Congress doesn't act and in the courts when need be to represent our patients and physicians for what is good for patients and for what physicians need to provide care. No longer can we live in a professional vacuum. Too often, we talk to ourselves. Too often we meet as our hospital staffs and discuss the issues there. We often ignore public perceptions of physicians and of the medical field.

The AMA is out to create a climate of understanding for the public and a balance between our professional self-interests and concerns with the activities we do on behalf of the health of the public. Again, we must reach out to the public and to all the institutions that are a part of that public and the various groups that are represented and again build consensus, build coalitions, build agreement on what is best for medicine—always representing the physician's viewpoint on how they can deliver the best care to the American people.

The AMA is following this prescription and the impact is already apparent. You recall we had one hundred thousand plus responses to the RBRVS conversion factor—the first time it has ever happened. We had 85% of Congress supporting it. We even had the press supporting that effort. The end result was we did see some changes. Now, the key impact is that members

of Congress are now calling us and their staffs are now contacting us before they introduce legislation. For the first time we are beginning to come in on the front end instead of in the reactionary stage. And most importantly too, there is a better feel and a willingness to introduce legislation that we want to see achieved in order to correct the many problems in our over-regulated system.

The end result of all this is the AMA's image is changing. Changing from that reactionary mode to one of proposing solutions to difficult problems and aggressively focusing on what is good for medicine, good for patients, good for physicians, and of course, good for the health of the public.

Let me call your attention to three important areas where we place at high priority. First is the whole area

of patient-physician advocacy. That deals with all of the things that affect the one-to-one relationship between the doctor and patient as your delivering their care. But most important at the moment and of concern to all of you, is the physician payment reform that is now being put into play.

Over the next several years we will need to see about the care and feeding of the RBRVS. We must make sure it's accurate. We must make sure it's fair. We must make sure it's equitable. And, most importantly, we must make sure the corrections that are needed get put into place. That's why we have already formed, and if you saw the final regulation the AMA has mentioned as being the group who has assembled all of the specialties into an RBRVS updating group to advise HCFA on the recommendations needed. It's that type of effort that we believe will be most helpful in shaping the direction of payment reform.

But underneath all the reform, is the ultimate need to negotiate. Right now each of us individually negotiates with that insurance company or with the Medicare carrier and that level field has sort of tilted and not in our direction. We are now working in every way possible in our contacts with Congress to get them to realize that in order to have good health care reform we will need to be able in some way to have a negotiating mechanism and level out that playing field for physicians.

I mentioned health care reform because that too is the wave of the future. How are we going to be able to practice medicine? Here again, the AMA is out front having proposed over two years ago a health care reform activity we call Health Care Access America. That builds on the strengths of our current system and corrects those things that are weak about it. The way we propose is to reform Medicaid through national eligibility standards at 100% of federal poverty and a set of basic benefits which have been defined by the AMA House of Delegates. By phased expansion of the employer-based insurance so that we bring and gradually expand that insurance package by basic insurance benefits and by insurance reform that allows the insurance package to be purchased at a lower level for the small employer.

And finally for recognition that we have to put together some cost package that deals with the issue of rising costs—dealing with the unit costs, the RBRVS, the parameters, the amount of care that is appropriate, the liability reforms, the simplification of the system. Think of what a single form for every insurance carrier would mean in making our lives easier and a variety of other things including patient education on how to use the system and better information on the fees charged.

We also believe ours is the only one that provides continuing support for education and for research to maintain the quality of care and continue the tremendous advances that we have made in this country in health care delivery.

The final part of this is the profession itself. A return to professionalism—putting the patient first, asking every physician in this country to rededicate themselves to the ethical standards and principles that make up our profession and make us unique. And, of course, to maintain the standards in education and practice and in the competence of the physician group.

One part of the spin-off of the negative comments that you read in the press about a physician who did something wrong is that we never recognize the good physicians. We never recognize those of you here with a positive attitude that says you're doing a good job. The AMA is looking at ways that we can look at that 99.44% of physicians who do a good job. You can make yourself proud to be a physician and more importantly, to be able to deliver the best care to your patients.

These activities where we are concentrated really are undergirded by increased efforts in communication, you'll see that, with a variety of ways of trying to get the message of what we are doing out to you including quarterly videos that you can have for your hospital staff, newsletters, and other types of bulletins that will keep the Arkansas Medical Society as well as everyone else informed.

One important part of shaping that climate we live in so the public better understands us is now a new CNBC series in which you will see the AMA presenting some 10-12 hours a week of medical programming about half of which will be directed at the public and trying to inform them not only about what is good medicine but about the issues that you as doctors face in trying to deliver their care.

Another part that you may have received from Good Housekeeping, is a consumer magazine which we are publishing jointly with the Hearse Publishing Company. The test magazine is on the stands at the moment. We're not collecting information and we believe that that will be successful. If so, we again have another outlet to give medicine's viewpoint to the public and to

help the public learn to live better, more productive and health lives.

The final part of what I wanted to say this afternoon deals of course with two more important areas. Membership obviously affects you and membership affects AMA. We have a long range plan for membership. Our credibility needs to be improved by having over 50% of the doctors in this country, whether they practice or not, be members of AMA. We hope to work with you at the state, county, and specialty societies and everyone else to get everyone to recognize that we are all in this together. If we collectively join and have a strong voice, we can have a more effective representation at all levels throughout the evolution of this new health care reform.

The final part is simply federation unity. We have got to keep that partnership going. These are stressful times. It's easy to see how we can fragment and particularly how the specialty societies or some other group move away from and try to make it on their own. That's what Congress and other people want—fragment us and pick us off one by one. So keeping that professional team together is a major effort at this point. What it will take to win in the 90's is a strong team and teamwork, using all those talents and skills that all the organizations have.

Secondly, a game plan. Just as Arkansas always seems to have a better one than Texas when we played them in football, we need that type of flexible game plan. It can change as the situation changes yet everybody understands what each play is going to be doing. The willingness to take risks and most of all confidence in ourselves that if we stick together and play as a team, if we follow the plan that we will ultimately win. What we will win is basically the shape of the new system under which health care will be delivered in this country.

But winning also demands one other thing—that every physician do their best when they take care of their patients. They should provide that caring, touching concern that every one of us needs when we are ill and which is the best medicine beyond what you can give them in pill form or by injection. Added to that every physician, whether playing on the team actively involved or sitting in the stands rooting or really on the sidelines waiting to go in, needs to stand behind and root on the team that's going to represent all of us ultimately in those decisions when they are made.

I want you to know that the AMA has a great team and you are part of it. We have a good game plan and you are a part of that. We are fighting and you are a part of that. Ultimately, with you help and with your support, I think we can assure that medicine will continue to advance and that each physician will have the ability to provide the right amount of care in the right place at the right time for the right reason in serving our patients.

Thank you very much. ■

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Address by Mrs. Rita Rodgers

1991-1992 President
Arkansas Medical Society Auxiliary

Mr. Speaker, Dr. Warren, House of Delegates:

Greetings from the Arkansas Medical Society Auxiliary.

Our emphasis for the year was "Toward the Year 2000-A New Decade, A New Resolve." We chose that theme because, although there will be many changes in the world of medicine in the next decade, we intend to analyze those changes and meet the challenge of the future in the most effective way possible.

Sandy Harrison, the in-coming president, and I made a special effort this year to visit as many organized counties as possible to get to know our membership on a more personal basis and to re-acquaint members with the benefits of AMA and Auxiliary membership.

We found auxilians across the state working very hard to help their communities in many ways—through auxiliary, through schools, churches, homes, and other volunteer organizations. They were raising money for good causes, promoting health education and healthy lifestyles, and projecting a positive image of medicine.

Our primary goals for the future are to continue these community-based efforts. We intend to become increasingly more politically active on behalf of medicine. We intend to continue to raise funds to support medical education and research. We intend to continue our emphasis on improving adolescent health with a seminar in the fall which you have so generously supported. We intend to continue working on increasing our membership and membership participation.

We want to thank you for the great support you have always given our endeavors. I want to thank my personal physician, Charles Rodgers, who has supported my endeavors this year, both emotionally and financially, in my year as president. We want very much to support you in your efforts to improve the life of the physician and the physician's family. We know that through the efforts of our educated and motivated membership, we can accomplish all our goals. ■

Address by Mrs. Sancy H. McCool
Chairman, AMA-ERF Committee
American Medical Association Auxiliary

I am delighted to bring you greetings from the more than 70,000 auxiliary members across the country, and for the opportunity to emphasize again how important it is for medical societies and auxiliaries to work together to make a difference on the issues that matter to all of us. Particularly in today's environment when medicine is undergoing so many changes, many of which you have little control over, and the people in our communities, your patients, need our help to understand and cope with the myriad health concerns they face.

No one understands better than the medical family how these issues affect the delivery of health care in this nation.

We have worked with you this year on several important issues in the legislative arena. On RBRVS, we helped you generate the greatest amount of grassroots mail ever on a single issue. We have had a part in making medicine's voice heard on student loan deferment and forbearance bills, as well as on payment iniquities for the new physicians.

Our phone banks give us the ability to mobilize efforts to help get medicine's viewpoints across to legislators in Washington and in our state capitols.

Auxiliaries are also working with their medical societies to develop voter registration drives that will ensure that the health care community votes in this landmark election year—to ensure that elected officials consider medicine's point of view when they develop laws and regulations.

In the community health area this year, our members in cooperation with the AMA, focused attention on the campaign against family violence. We sponsored local shelters for abused children, programs to educate the public, and community resource lists that physicians can offer patients who are victims. In the coming year, we hope to work side by side with you in forming violence prevention committees in our local communities to help stem the tide of family violence that has reached such epidemic proportions.

We are also working with you in thousands of hands-on programs that provide health care to those who can't afford it, that teaches teens about the dangers of substance abuse, that help people understand AIDS and HIV infection, that provide mothers with what they need to give their babies a healthier start on life, and that keep our older Americans living independently.

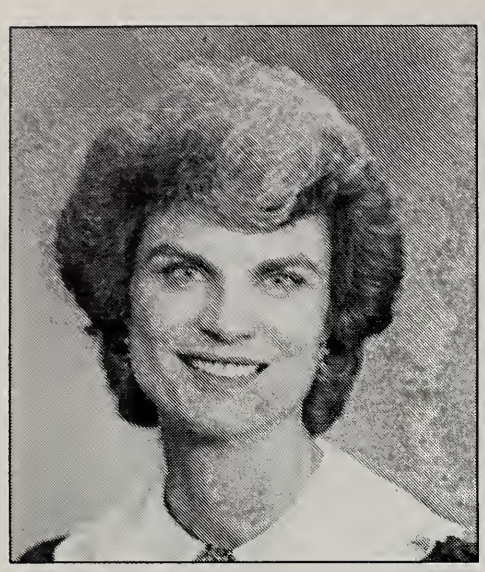
Over 1,400 health programs were sponsored in local communities by auxilians this year, resulting in media coverage that depicts physicians and spouses as we truly are - caring, concerned, involved members of our communities.

And I know I don't have to tell you what an outstanding job we do in raising funds for medical education. Last year we contributed $2.4 million to medical schools through the AMA-ERF, and for this year we are well on the way to our goal of a 2% increase in contributions. These record donations, of which $30,689.95 went to the University of Arkansas College of Medicine, will help ensure that quality education continues in this country.

Our cooperative efforts are vital if we are to make a difference on the issues that matter to those of us in the medical community. Working side by side, physicians and their spouses can combine their knowledge and abilities and energies into a force that will help see that we have a say in what happens in health care in this nation.

We thank you for your guidance and support of our work, and we hope that it will continue, for if ever there was a time to stand united in our partnership, it is today.

Only the unified effort of the medical community will help us reach the goal we share, the goal held dear by both of our organizations - quality health care that is accessible to every citizen in every community in this nation. ■



Address by Mrs. Ebba Dunn

1992 President-elect
Southern Medical Association Auxiliary

Thank you so much for giving me the opportunity to be with you today in your capital city—so close to your beautiful Ozark Mountains, your famous Hot Springs, and the home of the late, wonderful Sam Walton. It is very special to be in Arkansas any day, but today Arkansas is making the headlines on the political front—your governor's name is almost a household word!

Since politics are in seasons, I am reminded of the story of another politician who was trying to convince a voter to vote for him. The politician bragged about his greatness, never mentioning his flaws, which the voter know so well. Finally the voter in exasperation said, "I would not vote for you if you were St. Peter himself!" The politician was shocked, but like all politicians he had a comeback. He drew himself up proudly and said, "Well, if I were St. Peter, you would not have a chance to vote for me because you would not be living in my district!"

I don't live in Arkansas, but I have a kindred spirit for your state. We are so pleased that the University of Arkansas is now in the Southeastern Conference, where Alabama and Auburn will be playing your teams on a regular basis. We are proud of your athletic record, especially in football and basketball.

This kindred spirit is also felt in the Southern Medical Association Auxiliary of which many of you are members. As southern states we have a common bond which helps sustain us as we work together to accomplish our goals, which are many.

The Southern Medical Association Auxiliary theme for this year is Share the Vision." Dr. Rubert Schuller of the "Hour of Power" said, "Build a dream and the dream can build you." This year in the SMAA we can paraphrase this to say "Build a visions and the vision can be a reality when it is shared."

With the magic of a common cause and in the kinship of the medical family, we share the vision of a clean, healthy environment, a nation under God, and freedom for all people. We are quire concerned about health care both locally and globally.

Encompassed in our caring is the vision of what can be accomplished through the Southern Medical Association Auxiliary that will make a difference. One of the most important things we are currently doing is to develop breast cancer awareness. To provide leadership for this project, a Breast Cancer Awareness Committee has been formed including a representative from each state. Mary Gardner is serving on this committee representing Arkansas. As women, helping to prevent this dreaded condition is important to all of us. In 1991, 44,500 women died of breast cancer. We know that the key to the cure is early detection. Look around you. One out of every nine to you in this room could have breast cancer. Our vision is to encourage awareness in women throughout this nation, beginning with ourselves.

SMAA is working in coalition with the American Cancer Society on a billboard that is made available to you at a nominal cost. A poster was included in the current issue of Southern Connection. It can be torn out and taken to beauty shops, dress stores, aerobics centers, etc., to inform people about the necessity of early detection. Multiples of the poster are available from the SMAA office. Beautiful birthday cards which include a reminder to have a mammogram are also available from the SMAA office.

Our encouragement may be all that is needed. Let's make it a personal goal this year to reach one person about breast cancer awareness—Each One—Reach One.

We continue to be proud that it was through SMAA's efforts that President Bush proclaimed March 30 as National Doctors' Day. This year, many states emphasized community service projects for Doctors' Day, such as Fun Runs for low cost mammograms, breast self-examination seminars, and use of the new mammogram billboards. Many have effectively used the new Doctors' Day note cards.

Another vision we are sharing is the preservation of medical history, including the recording of those interesting not-to-be forgotten tales of early medicine. As we all know, our medical heritage is in our hands. Thanks to all of you for preserving the medical heritage of Arkansas.

Two new committees have been formed to help us keep track and compile successful projects. These committees are the Doctors' Day Access and Medical Heritage Access Committees. Sandra Jacks is serving on the Doctors' Day Access Committee—please tell her about your projects, both past and present.

I want to extend to you a warm personal invitation to accompany your doctor to the 86th Annual Scientific Convention, November 12-15, 1992 in San Antonio, Texas. San Antonio is a unique city. Several new attractions have been added since Southern was there last—among them Sea World and a very special country music theme park. You will savor lip smacking country fare, fajitas and margaritas, as well as elegant cuisine. Southern is well known for its conventions, and I guarantee, this one will be no exception. The boots will be polished, the ten gallon hats will be worn, and the welcome mat out. So, ya'll come!

Thank you so much for having me in this beautiful state. I enjoyed being a part of your meeting and being with you. ■

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Arkansas Medical Society Auxiliary Convention Report

Mrs. Mary Ann Stallings

The 68th Annual Session of the Arkansas Medical Society Auxiliary was held April 9-11, 1992, at the Excelsior Hotel and Statehouse Convention Center in Little Rock in conjunction with the Annual Session of the Arkansas Medical Society.

Mrs. Loretta Banowsky, a physician spouse from San Antonio Texas and chairman of the Texas Medical Association Auxiliary TEX-PAC, spoke at the Leadership Conference on Thursday, April 9, on the importance of how to be politically active and effective on behalf of the medical profession. She encouraged spouses as well as physicians to run for political office.

Following a presentation by Karen Kozlowski, M.D., assistant professor of obstetrics/gynecology and pediatrics at UAMS and director of pediatric adolescent obstetrics/gynecology at Arkansas Children's Hospital, on "Healthier Youth by the Year 2000: Adolescent Pregnancy," the opening general session convened at 9:30 a.m., Friday, April 10. Special guests present were George Warren, M.D., president of the Arkansas Medical Society; Joseph T. Painter, M.D., chairman of the Board of Trustees of the AMA; Larry Lawson, M.D., president-elect of the Arkansas Medical Society; Ken LaMastus, executive vice president of the Arkansas Medical Society; and Kay Waldo, director of administrative services of the Arkansas Medical Society.

The group was addressed by Mrs. Sancy McCool, a former Arkansan now residing in Baton Rouge, Louisiana, who serves as AMA-ERF chairman for the American Medical Association Auxiliary. A business session followed.

On Friday afternoon after the Shuffield Lecture/Luncheon board members, delegates, and guests were invited to hear Gail S. Harber, MS, NCACII, CCDCIII, speak on "Empowering the Family." Mrs. Jo Ann Browning, chairman of the Arkansas Medical Society Auxiliary Support Committee, served as moderator for a panel of medical spouses.

The executive director of the Family Clinic, Ltd., in Little Rock, Brian A. Baker, MHSA, MPA, BA, spoke Saturday morning, April 11, on the topic "Toward the Year 2000: Medicine's Future, Planning for Change."

Special guest Mrs. Ebba Dunn, president-elect of the Southern Medical Association Auxiliary, was introduced at the second general session and addressed those present.

Mrs. Jo Ann Campbell, chairman of the American Medical Association Auxiliary Nominating Committee, presented the following slate of officers for 1992-93:

President: Mrs. Sandy Harrison (William)
President-elect: Mrs. Arleta Power (Robert)
Recording Secretary: Mrs. Gypsy Steele (William)
Treasurer: Mrs. Pat Kyser (James)
Northeast Vice President: Mrs. Mary Ann Stallings (Joe)
Northwest Vice President: Mrs. Michelle Rogers (David)
Southeast Vice President: Mrs. Brenda Gullett (Robert)
Southwest Vice President: Mrs. Ann Wallace (Thomas)

The officers were accepted by acclamation and were installed at a luncheon following the adjournment of the second general session. ■

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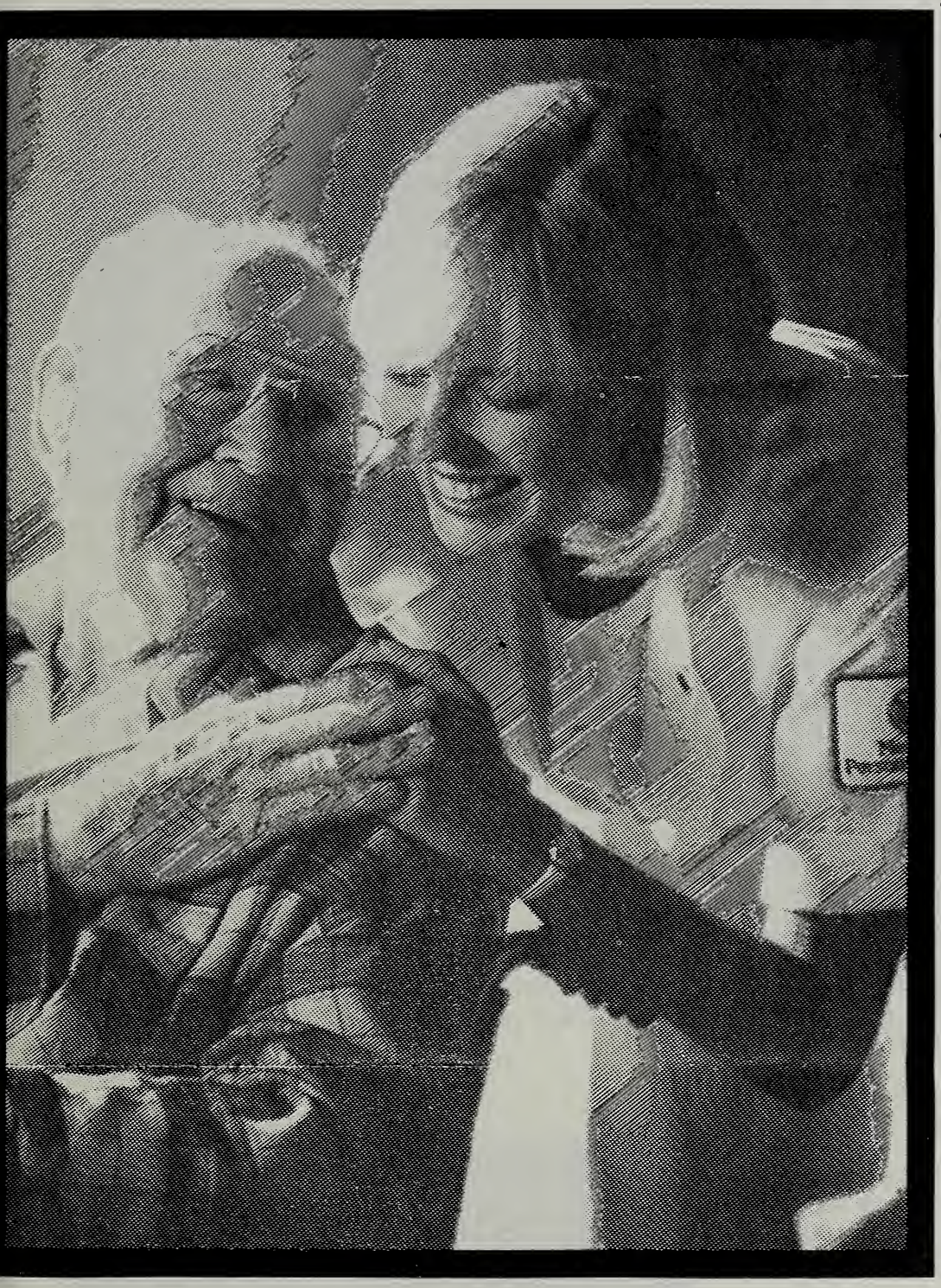

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In Memoriam

Society Members

John W. Ashby, M.D., Benton
Robert H. Atkinson, M.D., Hot Springs
Charles C. Ault, M.D., North Little Rock
James W. Branch, M.D., Hope
Joe W. Chamberlain, M.D., Hot Springs
Thomas F. Dilday, M.D., Little Rock
Jack T. Dobson, M.D., Fordyce
R. Kirk Drange, M.D., Rogers
Thomas M. Durham, M.D., Hot Springs
James H Fraser, M.D., Little Rock
Edwin F. Gray, M.D., Little Rock
Ralph B. Hamilton, M.D., West Memphis
L. Gordon Holt, M.D., Little Rock
Harry Jack "Hank" Jordan Jr., M.D., Jonesboro
Ray W. Leavelle, M.D., Texarkana, Texas
Vincent Lesh, M.D., Fayetteville
George E. Mitchell, M.D., Fort Myers, Florida
Doane M. Newton, M.D., Hot Springs
V. Earl Parsons, M.D., Arkadelphia
Malcolm O. Peeler, M.D., Jonesboro
Bascom P. Raney, M.D., Jonesboro
Mason Robbins, M.D., Fayetteville
Robert L. Sherman, M.D., Fort Smith

Auxiliary Members and Spouses

Mrs. Omer E. Bradsher (Rose), Paragould
Mrs. James R. Fall (Mildred), West Memphis
Mrs. Charles E. Garratt (Lucille), Hot Springs
Mrs. Ellery C. Gay Sr. (Allie), Little Rock
Mrs. Edwin F. Gray (Ruth), Little Rock
Mrs. William B. Grayson (Florence), Little Rock
Mrs. Walter P. Harris (Louise), Danville
Mrs. F. Paul Hogue (Alice), Benton
Mrs. Wesley J. Ketz (Jamie Frances), Batesville
Mrs. William E. Knight (Mary), Fort Smith
Mrs. Randolph Murphy (Carmen), Little Rock
Mrs. C. Fletcher Watson (Ruth), Little Rock
Mrs. J. Earle White (Gloria), Fort Smith

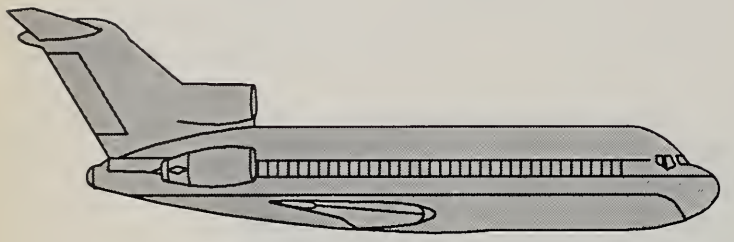
Fifty Year Club

The Fifty Year Club is composed of physicians who, for the past fifty years, have loyally and effectively served the community and, by skill and devotion to high ideals, upheld and maintained the standards of the medical profession.

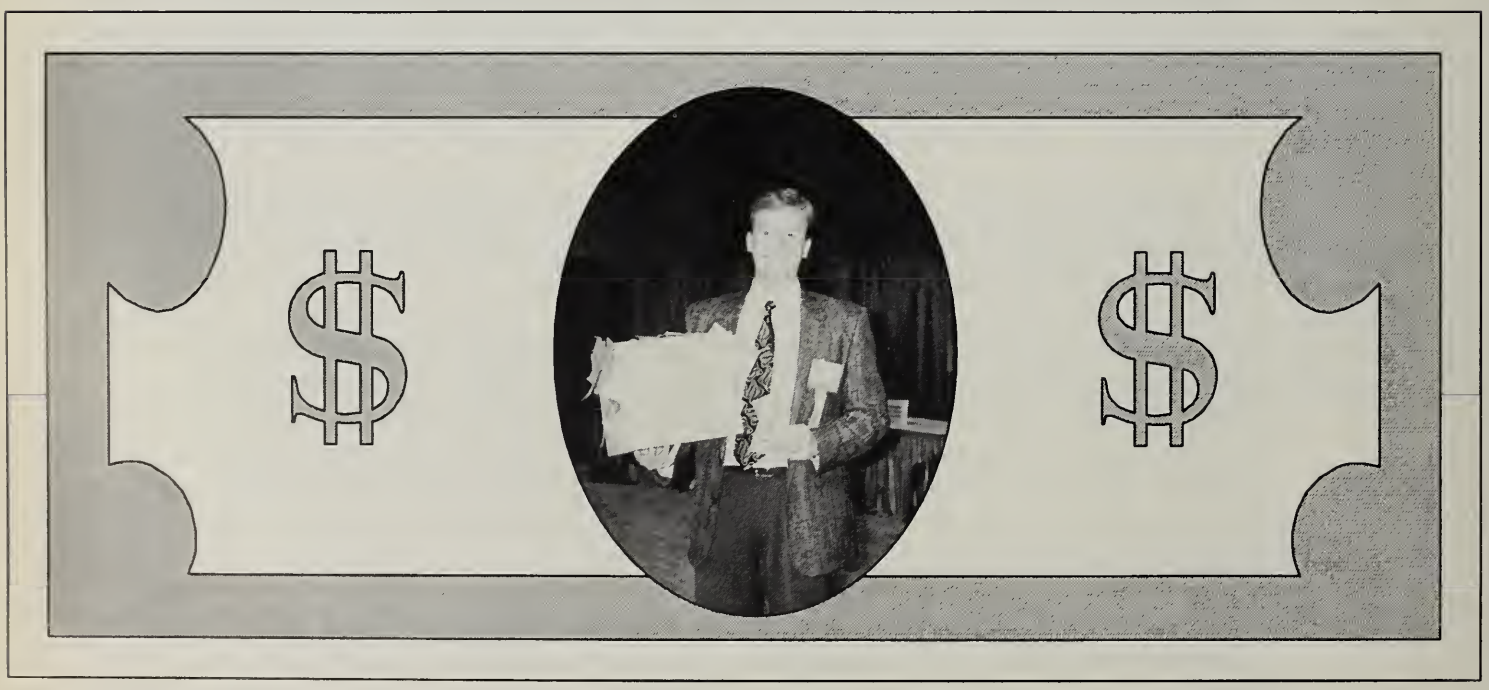
Dr. Henry Kirby of Harrison, President of the Fifty Year Club, presided over the meeting. Physicians attending the Fifty Year Club Luncheon were Drs. Dale Alford, John Ashley, Max Baldridge, Robert Carnahan, Gilbert Dean, Ross Fowler, Vida Gordon, John Greutter, John Guenthner, John Herron, James Huskins, Alfred Kahn, Henry Kirby, Joseph Ledbetter, Ruth Lesh, Art Martin, Jim McKenzie, Max Mobley, Joseph Norton, William Reese, Ben Saltzman, James Smith, John Sneed, Bryant Swindoll, H.W. Thomas, Peter Thomas, Vernon Toombs, Joe Verser, and Robert Watson.

Dr. Joe Verser of Harrisburg was elected President for 1992-1993. Dr. Ben Saltzman of Mountain Home won the door prize, a figurine hand-carved by Dr. Henry Kirby.

1992 AMS Grand Prize Winners



Dr. Anthony Hui, of Fayetteville, was the winner of the physician grand prize drawing held at the 116th Annual Session of the Arkansas Medical Society. Dr. and Mrs. Hui will enjoy two round trip airline tickets to anywhere in the Continental U.S. The tickets were donated and presented by Ms. Lynn Hayes of Tours and Travel of Russellville.



Mr. Chris Beagle, of Arkansas Express Claims, was the winner of the exhibitor grand prize drawing held at the 116th Annual Session of the Arkansas Medical Society. He received $200 cash.

1992 Shuffield Award Winner

Mr. Paul Harris

Mr. Paul Harris, of Little Rock, was presented with the 1992 Shuffield Award by the Arkansas Medical Society. The Shuffield Award is given each year to recognize a non-physician who has made significant contributions to their community in the area of health care. The award is named in honor of the late Drs. Joe and Elvin Shuffield, a father and son team from Little Rock, for their many years of service to the Arkansas health professions.

Mr. Harris has served his entire adult life serving physicians, their patients, and the public at large. He has served as Executive Director of the Pulaski County Medical Society since 1961 and founded the Pulaski County Medical Exchange in 1963. In these roles, he has referred countless numbers of patients to area doctors; given counsel to hundreds of patients and physicians on a wide range of problems; assisted thousands of patients needing to speak with their doctor in an emergency situation; and, in general, facilitated the doctor-patient relationship for numerous residents in Pulaski County. He founded the Senior Physicians of Arkansas in 1984 and recently served on the Arkansas Medical Society's Committee on AIDS.

In the early sixties, he coordinated the Pulaski County Medical Society's Polio Immunization Program, which resulted in the administration of over 300,000 individual doses of vaccine.

Though his service to physicians and their patients is often quiet and behind the scenes, the members of the Pulaski County Medical Society recognize that they have a true friend in Paul Harris.

Steering Committee

William N. Jones, M.D., Chairman

Interesting Profile Emerges Amid the Clouds of Smoke

Now that the Coalition for a Healthier Arkansas (CHAR) has proposed a 25-cent increase in the state tax charged on tobacco products, some Arkansans want to know just who is the likeliest to pay that tax whose revenues, after 1993, will be earmarked for medical care, health education, research, senior services and research into smoking-related diseases.

The answer is, "Smokers only will pay the tax."

But who are they? Who smokes in Arkansas?

The Arkansas Department of Health in 1991 completed a thorough demographic survey of Arkansans' inclinations toward smoking. And this is what emerged from the survey - a scientific poll that sampled opinions of a diverse group of 1,329 Arkansans, all ages 18 and older:

- About 26.5% of those surveyed smoke. Since the 1990 census reported that 623,705 of the state's 2.35 million residents were children or teenagers under 18, that means the state as a whole has fewer than 458,000 smokers who, with minors, buy 294 million cigarette packs a year.

- Generally, the greater the education level of the individual, the less likelihood there is that he or she smokes. Just 22.8% of those earning more than $50,000 smoke. Twenty-one percent of students surveyed smoked.

- Arkansans who remain unemployed for a year or longer were far likelier (50%) to smoke than those who were jobless for less than a year (38.8%) or those gainfully employed (26.4%).

- Fewer than one in four college graduates (24.1%) now smokes. Yet 40% of technical school graduates smoke, as do 34% of those with only some high school education.

  Thirty percent of those who have graduated from high school smoke, as contrasted to 13.6% of college grads and 19.3% (about one in five) of those having post-graduate education. About one in five (20.8%) Arkansans with a ninth-grade education or less is a smoker.

- Male smokers were fewer (21.2%) in Arkansas' 18-24 age group and more prevalent (35.4%) among Arkansans in the 25-34 age group. In all, 30.3% of Arkansas men smoke.

  Among Arkansas women, however, smokers were most prevalent in the 25-34 age group (32.7%) and the 18-24 age category (30.8%). Overall, 22-24% of Arkansas women now smoke.

- Nearly 30% of Arkansans ages 18-64 smoke but, among those ages 65 and older, smokers comprise fewer than 15%. Fewer than 20% of Arkansas retirees smoke. Physicians have urged many to quit.

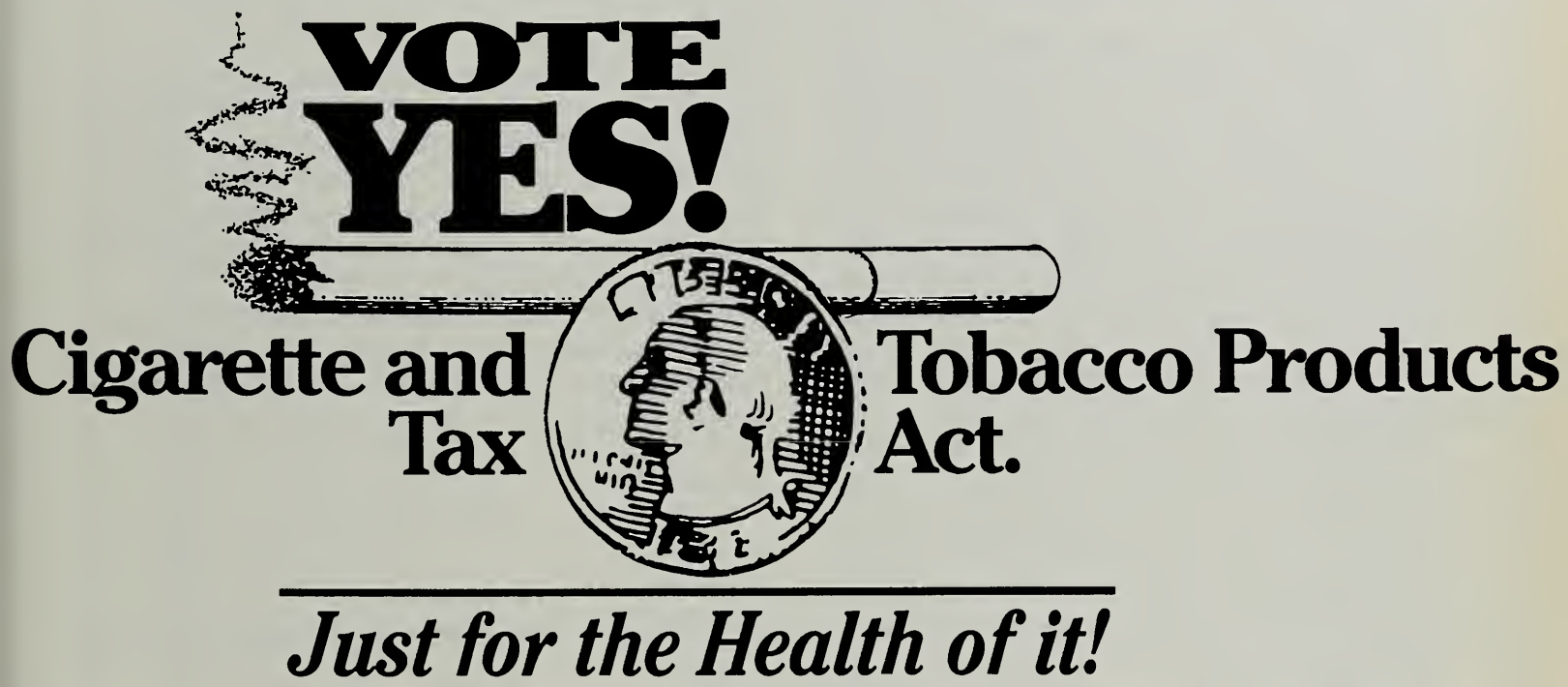
- More than one-fourth of Hispanics polled smoke, compared to fewer than 18% of blacks and 28% of non-Hispanic whites.

- Marital status seemed to make a vast difference in one's penchant for smoking. Just one in four married Arkansans (24.4%) smoke; but that percentage rises to 38% among those separated from spouses, and it approaches half (48.6%) of divorcees. Among single Arkansans who have never married, 23.4% were smokers.

Doug Murray, a spokesman for the Health Department's Center or Health Statistics, said the 1991 smoking survey included 1,329 respondents whose data is included in the Behavioral Risk Factor Surveillance System.

CHAR began its petition drive March 27 seeking signatures of 55,000 registered Arkansas voters to put the proposed Cigarette and Tobacco Products Tax Act on the general election ballot for a November 3 vote.

Nearly two-thirds of Arkansans polled this year said they favor such a surtax on tobacco, provided that the estimated $68 million in annual revenue is earmarked specifically to aid all Arkansans, including smokers.



70% to Aid Seniors

The Act specifies that the state General Assembly will appropriate half the revenue - about $34 million a year - to be matched 3-to-1 with federal Medicaid dollars. That $132 million will pay soaring hospital, prescription and other medical bills of older indigent Arkansans, many having costly, smoking-related diseases.

Another 20% of the revenue will support various senior services, especially Meals on Wheels nutritional programs and transportation services for the elderly.

About 15% would pay for health education programs intended to deter young Arkansas children from the health hazards of smoking, alcohol consumption and drug abuse. The rest would be allocated for helping families, abused and neglected Arkansas children, and for research into treatment for smoking-related diseases such as lung cancer, emphysema and heart disease.

William N. Jones, past president of the Arkansas Medical Society, chairs the Steering Committee for the Coalition for a Healthier Arkansas.

Tobacco Tax Hasn't Kept Pace

Dr. Jones said that the state's cigarette and tobacco tax had lagged far behind the rapid price increases which tobacco companies have spurred the past few years. About one-fifth of the cost of a pack of cigarettes now goes to federal and state tax, compared to about half that cost in 1970.

Smoking-related illness, Dr. Jones added, costs the state about $500 million a year in medical costs, prescription drugs, extended care in nursing homes, lost wages and productivity, and other losses. When smokers are unable to pay many of those costs, other taxpayers must.

High-Priced Habit

Dr. Jones said, when Canadians now are paying more than $5.77 a pack for cigarettes (the Danes more than $6.80), he considered it high time that U.S. smokers, too, begin paying the tab for the $135 million a year in direct costs (hospital, medical, prescription and nursing home fees) and more than $363 million a year in

indirect costs occasioned by smoking. Those costs also include expenses associated with heightened mortality, prolonged morbidity and lost productivity on the job.

A Growing Coalition

The Coalition now includes not only state chapters of the American Heart and Lung Associations and American Cancer Society, but also groups as diverse as the Governor's Advisory Council on Aging, Arkansas Dermatological Association, Arkansas Public Health Association and Campaign for Kids.

Like several CHAR affiliates, the Campaign for Kids is itself composed of several groups whose common bond is their concern for disadvantaged children, especially those who have been abused or neglected in their homes.

Other CHAR affiliate groups now include the Arkansas Medical Society, the Arkansas Hospital Association, the Arkansas Academy of Family Physicians, Arkansas Pharmacists Association, Association of Area Agencies on Aging, AARP, Advocates for Children and Families, Arkansas Home Health Care Association, Arkansas Association of Home Health Agencies, the Society for Public Health Education, State Dental Association, Arkansas Perinatal Association, Arkansas Public Health Association, the March of Dimes Foundation, and Blue Cross and Blue Shield of Arkansas.

Already, Dr. Jones said, several letters to editors of daily and weekly newspapers - some perhaps written at the urging of eastern tobacco companies such as Philip Morris and RJR/Nabisco - have begun appearing in the state's press. Usually, the letters allude to heavy taxation (although Arkansans pay some of the lowest taxes in the country) and some vague, nebulous "constitutional right" to smoke.

Those are typical criticisms major tobacco companies use in resisting taxation that hampers their ability to sell smokers, old and young, a product whose consumption almost inevitably leads to illness or death.

About 4,000 Arkansans die prematurely each year, the result of adverse effects of tobacco use on their health.

A Right to Choose

CHAR members believe that smokers, once they're mature enough to know the facts and recognize the harmful, death-dealing effects of smoking, indeed have every right to choose whether they smoke. However, tobacco companies disavow smokers' obligation to bear their share of the colossal social costs that their habit causes for all Arkansans.

That is all CHAR members are seeking to achieve by urging Arkansans to sign petitions for the Initiated Act - then to support it with their money now and their votes next November 3. ■

COALITION FOR A HEALTHIER ARKANSAS

P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

Dear C.H.A.R. Campaign Chairman:

I have read about the upcoming campaign for an initiated act to further tax tobacco sales in Arkansas, and I want to help all I can before the Nov. 3 vote.

Please contact me as a volunteer to:

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Coalition For A Healthier ARkansas

P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

The following physicians have contributed to the Coalition for a Healthier Arkansas, an effort endorsed by the Arkansas Medical Society. If you would like to add your name to the list of supporters, complete the pledge card on the bottom portion of the previous page and return it to CHAR.

Lawrence J. Abramson, M.D.	Blytheville
Jim Acklin, M.D.	Fort Smith
H. Daniel Atwood, M.D.	Fayetteville
James Beckman, M.D.	Fayetteville
Mike Berumen, M.D.	Fort Smith
Raymond Biondo, M.D.	North Little Rock
David Bourne, M.D.	Little Rock
Jay O. Brainard, M.D.	Little Rock
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Donald Browning, M.D.	Little Rock
Deland Burks, M.D.	Fort Smith
Wade W. Burnside, M.D.	Fayetteville
Kelsy Caplinger, M.D.	Little Rock
Robert Chester, M.D.	Fort Smith
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Arkansas HIV/AIDS Report 1983-1992

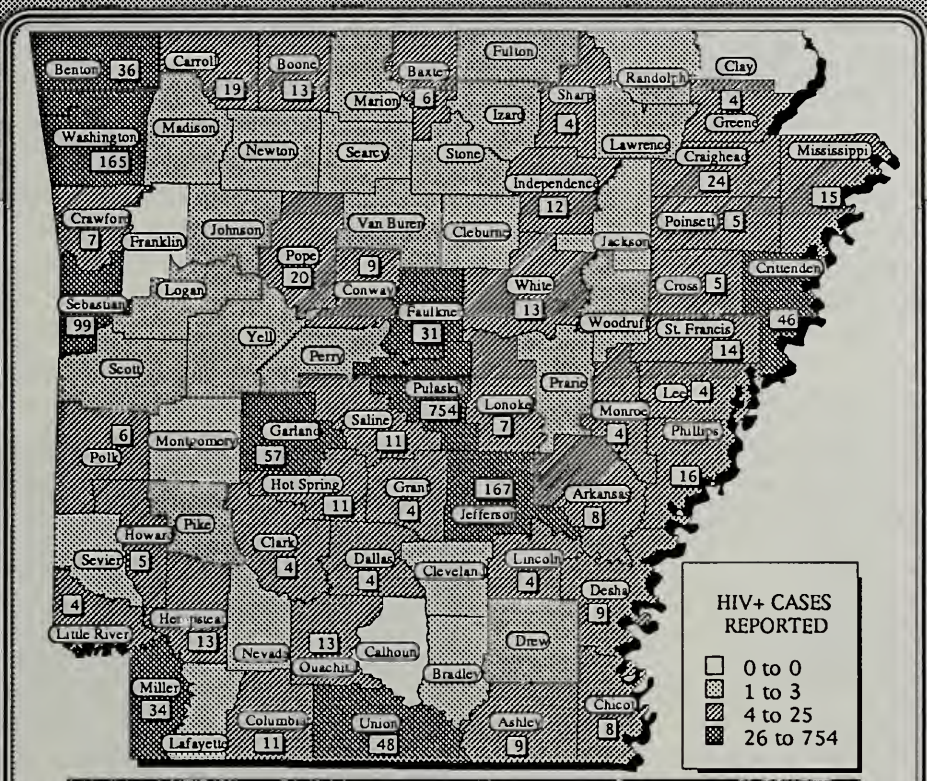
Arkansas: June 1983 through April 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	438	420	132	1,557	85.60
	Female	1	1	6	27	39	71	90	27	262	14.40
AGE	< 5	0	0	1	1	2	9	14	3	30	1.65
	5-12	0	0	0	1	1	5	2	0	9	0.49
	13-19	0	0	0	8	8	14	20	9	59	3.24
	20-29	8	10	15	109	124	192	152	74	684	37.60
	30-39	7	15	22	86	105	206	217	53	711	39.09
	40-49	4	7	11	24	35	61	72	14	228	12.53
	> 49	1	1	6	6	12	19	23	6	74	4.07
	Unknown	0	0	0	8	3	3	10	0	24	1.32
RACE	White	16	24	47	171	178	353	310	93	1,192	65.53
	Black	4	9	8	70	107	152	195	63	608	33.42
	Other	0	0	0	2	5	4	5	3	19	1.04
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	159	1,819	100%

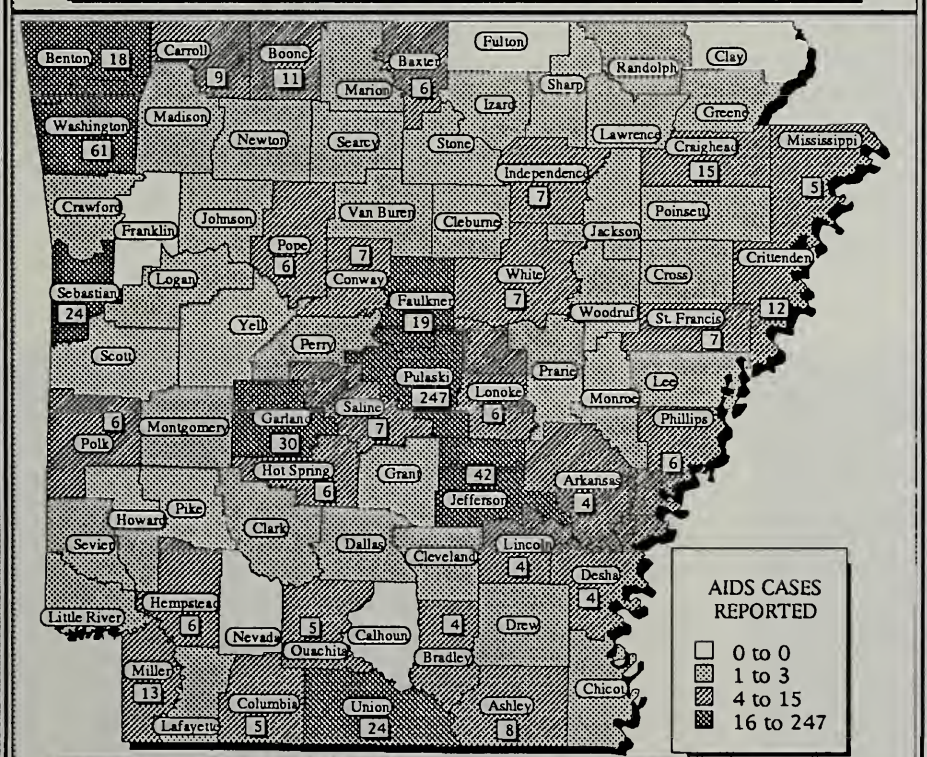
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	60	638	89.73
	Female	1	0	4	6	10	20	25	7	73	10.27
AGE	< 5	0	0	0	1	1	6	6	0	14	1.97
	5-12	0	0	0	1	0	1	1	0	3	0.42
	13-19	0	0	0	0	0	4	3	1	8	1.13
	20-29	7	9	15	27	24	55	57	20	214	30.10
	30-39	3	13	23	36	41	78	80	28	302	42.48
	40-49	1	6	8	10	7	35	41	12	120	16.88
	> 49	1	0	4	8	7	11	13	6	50	7.03
RACE	White	9	22	43	61	58	141	134	47	515	72.43
	Black	3	6	7	20	21	47	66	19	189	26.58
	Other	0	0	0	2	1	2	1	1	7	0.98
RISK	Male/Male Sex	7	17	31	59	50	118	118	43	443	62.31
	Injection Drug User (IDU)	0	2	10	4	11	18	28	7	80	11.25
	Male/Male Sex & IDU	3	9	4	6	6	18	17	1	64	9.00
	Heterosexual	2	0	2	3	6	10	10	6	39	5.49
	Transfusion	0	0	2	7	3	7	11	1	31	4.36
	Perinatal	0	0	0	1	1	6	6	0	14	1.97
	Hemophiliac	0	0	0	1	1	5	5	1	13	1.83
	Undetermined	0	0	1	2	2	8	6	8	27	3.80
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	67	711	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 1,819 Arkansans have been reported to be HIV+ as of April 25, 1992.



A total of 711 Arkansans have been diagnosed with AIDS as of April 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

AMS Newsmakers

Dr. John Bell, a Searcy radiologist and member of the Arkansas State Medical Board, has been appointed to the newly created Arkansas Task Force on Youth Entrepreneurship. The task force will study ways to stimulate economic development by empowering youth with free enterprise and entrepreneurial skills.

Dr. Otis Cutler, of Texarkana, is now one of three physicians in Texarkana to be board certified in emergency medicine. Dr. Cutler is a member of the senior medical staff of Wadley Regional Medical Center.

Dr. Jim English, a plastic surgeon from Little Rock, has been elected president of the Arkansas Academy of Otolaryngology, Head and Neck Surgery. Dr. English is head of the English Facial Plastic Surgery Clinic.

Dr. Christopher S. Johnson, a family physician from Rogers, has been appointed to the associate medical staff by the Springdale Memorial Hospital board of trustees to serve as a family practice physician. Dr. Johnson is in practice at the Rogers Medical Center.

Dr. Harmon Lushbaugh, a retired Fayetteville OB/GYN, has been recognized with the naming of a distinguished lectureship series endowment in his honor. The Harmon Lushbaugh Lectureship Endowment through Washington Regional Medical Center recognizes his 28 years of service to the area.

Dr. David McClanahan, a Fort Smith OB/GYN, has been named to the 1992 Citation Who's Who Among Rising Young Americans in American Society and Business. Dr. McClanahan is affiliated with the Holt-Krock Clinic.

Dr. R. Jay Mullis, a Fayetteville surgeon, has been appointed to the associate medical staff by the Springdale Memorial Hospital board of trustees to serve as an associate active surgical physician. Dr. Mullis is in practice at the Surgery Clinic in Fayetteville.

Dr. Carl L. Nelson, a chairman and professor of the Department of Orthopaedic Surgery and director of the Hip and Knee Surgery at the University of Arkansas for Medical Sciences, has been elected as a Specialty Society Governor to the Board of Governors of the American College of Surgeons.

Dr. Parthasarathy Vasudevan, a Helena urologist, was one of only eight people in Arkansas to be named a 1992 Channel 4 Community Service Award winner. The award is given to citizens whose volunteer efforts have made them an important contribution to their community.

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Radiological Case of the Month

Steven R. Nokes, M.D.
Charles C. Schock, M.D.
J. Zachary Mason, M.D.

History:

This 11-year-old girl presented with back pain.

Figure 1. AP lumbosacral spine.

Figure 2. Posterior bone scan.

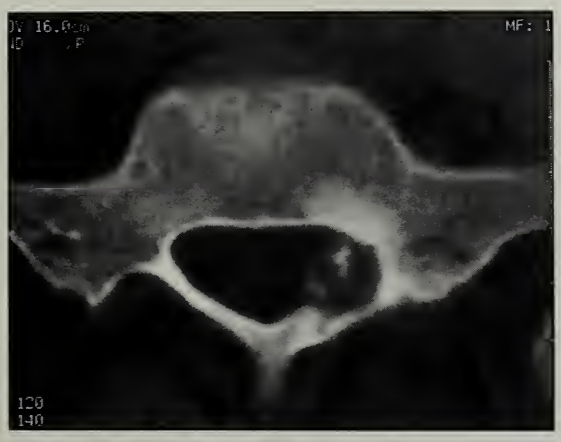

Figure 3. CT scan of S_1 (bone algorithm).

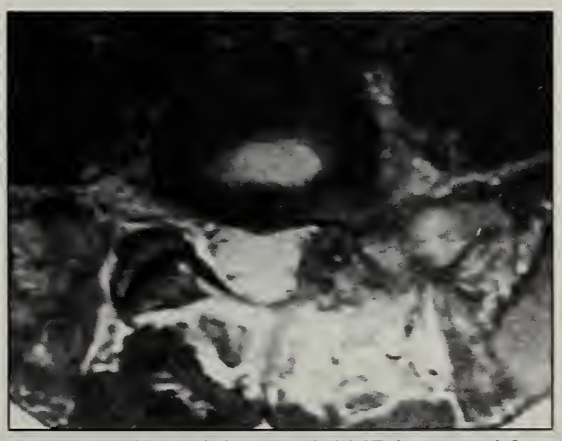

Figure 4. T_2-weighted axial MR image of S_1.

Osteoblastoma

Findings:

The AP radiograph reveals subtle sclerosis of the left S_1 pedicle. The bone scan demonstrates marked focal increased tracer accumulation in the same location. CT shows an area of bony destruction with an osseous matrix within the left S_1 pedicle and lamina with surrounding sclerosis. The MR scan demonstrates the mass with surrounding edema (bright signal) extending into the sacrum.

Discussion:

Back pain is an uncommon but highly significant complaint in children and adolescents. An aggressive approach should be undertaken to determine its cause, as frequently even minimal complaints are associated with major pathology. The differential diagnosis is extensive and includes mechanical derangements (overuse and herniated disc), developmental anomalies (spondylolysis/spondylolisthesis, Scheuermann's disease and scoliosis), inflammatory processes (diskitis, osteomyelitis and rheumatic disorders), hematologic abnormalities (sickle cell disease), and neoplasms of the vertebral column and spinal cord.

Every pediatric patient who presents with back pain should have AP and lateral plain films of the area in question. Oblique views are added if spondylosis is suspected. Plain films are often nondiagnostic and further imaging is required.

Radionuclide bone scanning is the preferred "next examination" in children with back pain and normal x-ray findings. While this is a very sensitive technique for localizing abnormalities, the specificity is low and additional focused studies are frequently necessary.

When the leading differential considerations are herniated nucleus pulposus, vertebral or disc space infection, scoliosis or tumors, a bone scan is probably unnecessary and MRI should be the procedure of choice following routine radiographs. MRI is an especially attractive modality in children, due to the absence of ionizing radiation. CT is reserved for subtle fractures and osseous tumors.

The findings in this case are classic for osteoblastoma, a rare benign primary bone tumor that occurs in the second and third decades of life. The vertebral column is the most common location, with the tumor distributed equally over the cervical, thoracic, lumbar and sacral segments. Osteoblastoma in the spine is usually a lytic lesion of bone arising in the posterior elements with cortical destruction and expansion into the surrounding soft tissues. Aneurysmal bone cyst, osteoid osteoma, and giant cell tumors will have a similar appearance. Bone scans invariably demonstrate intense focal increased activity and are helpful in detection and localization. CT is the definitive study. MR imaging is often confusing in osteoblastoma, demonstrating peritumoral edema ("flare phenomenon") that can be mistaken for a more aggressive lesion such as Ewing's sarcoma or lymphoma.

The treatment of choice is complete surgical resection, but incomplete curettage is effective in a high percentages of cases. The recurrence rate is 10-15%.

References

1. Bunnell, WP. Back pain in children. Orthop Clin North Am 1982; 13:587-604.
2. Afshani E, Kuhn JP. Common causes of low back pain in children. Radiographics 1991; 11:269-291.
3. Kroon HM, Schurmas J. Osteoblastoma: clinical and radiologic findings in 98 new cases. Radiology 1990; 175:783-790.
4. Crim JR, Mirra JM, Eckardt JJ, Seeger LL. Widespread inflammatory response to osteoblastoma: the flare phenomenon. Radiology 1990; 177:835-836.

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Contributor: J. Zachary Mason, M.D., is affiliated with Neurologic Surgery Associates in Little Rock.

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Hillyer, John W., Family Practice & Occupational Medicine, Bella Vista. Born, June 24, 1926, Cochabamba, Bolivia, South America. Medical education, University of Toronto, Ontario, Canada, 1953. Internship, Hamilton General Hospital, Ontario, Canada.

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Williams, John S., Family Medicine, Blytheville. Born, December 20, 1960, Memphis, TN. Medical education, UAMS, 1987. Internship/residency, St. Bernards Regional Medical Center, Jonesboro, 1990. Board certified.

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Goldsmith, Geoffrey A., Family Practice, Little Rock. Born, May 28, 1946, Santa Monica, CA. Medical education, McMaster School of Medicine, Hamilton, Ontario, Canada, 1973. Internship/residency, Santa Monica Community Hospital, 1975; Sunnybrook Hospital, Toronto, Canada, 1976; University of Washington, School of Public Health, Seattle, WA, 1986. Board certified.

Khan, Shagufta S., Hand Surgery, Little Rock. Born, November 9, 1947, Lahore, Pakistan. Medical education, Lahore, Pakistan, 1969. Internship, Cook County Hospital, , Chicago, IL, 1973. Residency, Mayo Hospital, Lahore, Pakistan, 1972; Cook County Hospital, Chicago, IL, 1978. Board certified.

Zuerlein, Terrance J., Neonatal-Perinatal Medicine, Little Rock. Born, July 31, 1959, Columbus, NE. Medical education, University of Nebraska College of Medicine, Omaha, 1985. Internship, Vanderbilt University Medical Center, Nashville, TN, 1988. Residency, University of Missouri, Kansas City, 1990. Board certified.

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Smith, Richard S., Internal Medicine. Born, December 12, 1958, Norfolk, VA. Medical education, Northwestern University, Chicago, IL, 1985. Internship/residency, USAF Medical Center, Keesler, MS, 1988. Board certified.

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McGaugh Jr., Ronald C., Family Practice. Born, September 6, 1963. Medical education, UAMS, 1992.

Nichols, Scott R., General Practice. Born, July 22, 1955, Lewisville. Medical education, UAMS, 1983. Internship, UAMS, 1984. Residency, UAMS & AHEC-Pine Bluff.

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St. John, Greg A., Internal Medicine. Born, December 25, 1963, DeQueen. Medical education, UAMS, 1990. Internship/residency, UAMS.

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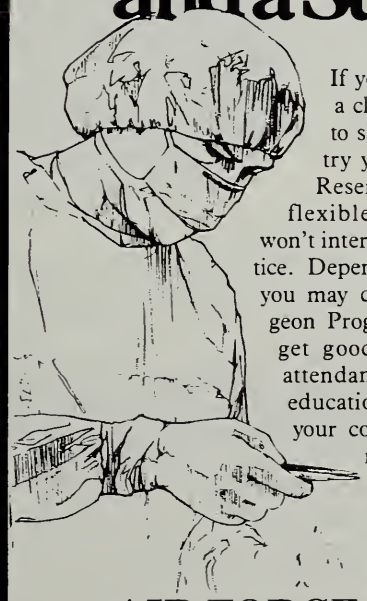

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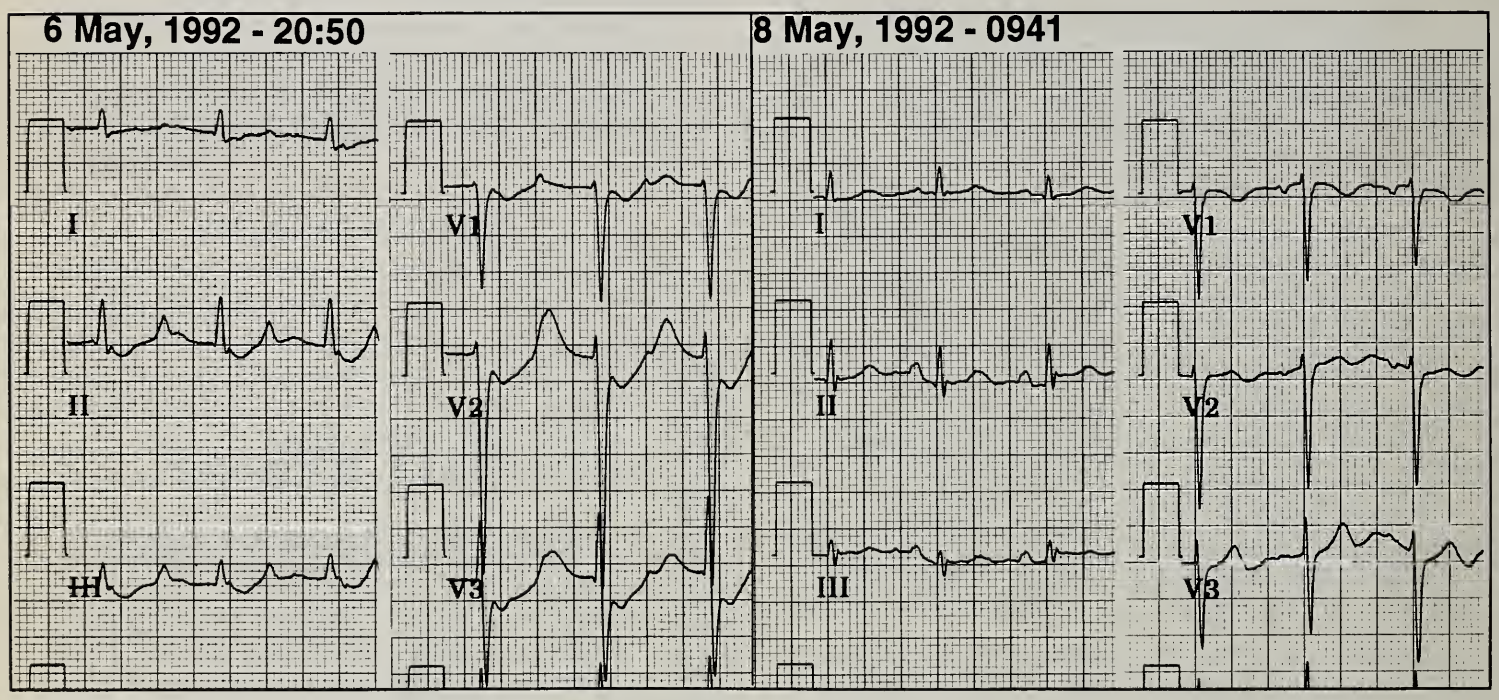
Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

The record on the left was obtained from a 58-year-old white male admitted for evaluation of confusion and a lung mass. The record on the right was obtained approximately 36 hours later.



DISCUSSION:

In the first record, sinus rhythm is present with a PR interval of 320ms, indicating first degree AV block. The P waves are tall and prominent in II, III and aVF. Identification of the P wave is facilitated by inspection of the lead II rhythm strip. The PR interval remains constant at 320ms while the sinus rate increases from 94 to 120 BPM over the first several complexes. Thus, the P wave moves closer to the preceding QRS. The QRS complexes are of normal contour and duration and the axis is normal. The most striking abnormality is the diffuse ST segment depression with what appears to be a prolonged QT interval. These are not T waves, but rather giant U waves. On inspection of the precordial leads, it is evident that the U wave is located in the PR interval of the following complex (see second RR interval in V1). Diffuse ST and T wave abnormalities are frequently caused by drug effects or electrolyte abnormality. This patient had severe hypokalemia ($[K^+]$=1.6 mEq/L) and hypercalcemia (Ca^{2+}]=14.6 mEq/L). In this instance, virtually all of the abnormalities in the ECG were related to hypokalemia. Hypokalemia may result in ST segment depression, decreased T wave amplitude and prominent U waves. The P wave may also become prominent and be associated with AV conduction disturbances. In this record, the combination of the prolonged PR interval and prominent P wave gives the appearance that the P wave is the T wave. The second record was obtained some time after correction of the hypokalemia. The PR interval is now 160ms, the T waves upright and the U waves no longer evident. Sinus tachycardia persists with a relatively short QT (320ms). These are both manifestations of the persistent hypercalcemia. The patient was found to have malignant melanoma with multiple osseous lesions resulting in hypercalcemia.

MODULATE/DEMODULATE MODEM ETHERNET SINGLE USER
EGA CLEARING HOUSE BI-SYNCHRONIS
PC-XT/AT XENIX
CGA ELECTRONIC CLAIMS SUBMISSION
MEGAHERTZ RAM REMOTE ACCESS VGA UNIX
ASYCHRONIS MEGABYTES ROM ARCNET
SERIAL PORTS MIPS
HIGH DENSITY
TACTILE HARD DISK
WORKSTATIONS VGA
9 PIN DOT MATRIX DATA TRANSFER
UNATTENDED POLING CPS
BARCODE RE
DOS PARALELL INTERFACE
MAGNETIC MEDIA MGA
MONOGRAPHIC ADAPTER
LOCAL PRINTER
AT COMPATIBLE BAUD RATE
WORM DRIVE A-B SWITCH
WEDGE DATA TERMINALS
MULTI-USER ENVIROMNEN
NETWORKING
ACCEPT ASSIGNMEN
CROSSOVER CLAIM EDS
CHARGE SLIPS HMO WRITE-OFF
CURRENT PROCEDURAL TERMINOLOGY
OUTSIDE LAB CHARGES
SUPERBILL PPO
WORKMAN'S COMP
ICD DIAGNOSIS CODES
REFERRING PHYSICIAN SECONDARY
GROUP NUMBER HICFA
PLACE OF SERVICE CODE
PRIMARY CARRIER
PRIOR AUTHORIZATION
TYPE OF SERVICE CODES
SAME/SIMILIAR INDICATOR
PATIENT CHARTS DAY SHEETS
SUPERBILL
CPT PROCEDURE CODES
WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN
ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE
DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT
APPROVED AMOUNT TYPEWRITER
CODING REQUIREMENTS
APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES DATE OF DISABILITY
SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO
DATE OF ACCIDENT PATIENT RECORDS RESPONSIBLE PARTY
INDIVIDUAL POLICY NUMBER

ELECTRONIC CLAIMS

STRAIGHT TALK.

SIMPLE SOLUTIONS.

FROM PEOPLE WHO SPEAK

YOUR LANGUAGE.

ARKANSAS EXPRESS CLAIMS

1-800-628-8274

Medicine in the News

Health Care Access Foundation Update

As of May 1992, the Arkansas Health Care Access Foundation has provided free medical services to 4,055 medically indigent persons.

The program has 1,496 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Little Rock Vascular Lab Accreditated

The Non-invasive Vascular Laboratory of Arkansas Vascular has been accreditated by the Intersocietal Commission for the Accreditations of Vascular Laboratories. This organization was recently established to insure the quality of studies done in vascular laboratories.

Arkansas Vascular is the first such laboratory in the state of Arkansas to be certified. The medical director of the laboratory is Dr. Edward C. Loebl, a vascular surgeon.

Electronic Claims Transaction Initiative

The Health Care Financing Administration (HCFA) has adopted a goal to virtually eliminate the use of paper transactions between providers and the Medicare contractor that pays bills.

In place of paper, HCFA wants providers to expand their use of electronic claims transactions. By 1993, HCFA hopes 95% of institutional providers will send in bills electronically; by 1994, the Agency wants 75% of other providers, such as physicians and medical suppliers, to do business with Medicare electronically.

HCFA has set annual targets toward its ultimate goal of achieving a nearly total electronic transaction environment. The current percent of claims which are submitted electronically is 76% for Part A and 42% for Part B. The interim targets for 1992 are 90% for inpatient, outpatient and laboratory bills under Part A, and 55% for Part B.

While expanding the use of electronic claims will help keep the Medicare program financially solvent by reducing administrative costs, it will also benefit hospitals, physicians, and other providers. For example, because electronic claims have fewer errors than paper transactions, providers can expect to experience fewer claim rejections. Electronic claims will also ease provider record keeping burdens and improve the process for verifying Medicare beneficiary eligibility information and responding to inquiries about the status of claims.

The HCFA Electronic Claims Transaction Initiative (ECTI) includes a 35-step Action Plan. HCFA's actions are intended to:

- enhance existing incentives for contractors and providers to communicate with Medicare electronically;
- remove whatever current barriers exist which prevent electronic transactions in certain circumstances;
- improve the sharing and dissemination of information among HCFA, the contractor and provider communities;
- better integrate different electronic technologies so that electronic transactions with Medicare will be simpler for providers; and
- increase the visibility of HCFA's actions in this area.

Provider participation in Medicare ECTI is now voluntary. HCFA hopes that providers will seriously weigh the advantages of electronic communications with Medicare and reach a decision to participate. Medicare contractor staff are prepared to assist providers who have not yet begun the transition to electronic transactions.

In the future, however, it is expected that providers will be required to submit claims electronically either through administrative regulations or Congressional action. The transition from a voluntary program to a mandatory program will be done incrementally. Initially, hospitals will be required to submit all claims electronically. It is then expected that mandatory requirements for other claims types will follow.

Statewide Healthcare Network

Baptist Medical System, the state's largest healthcare provider, announced a new way to gain access to medical services and good health - a sophis-

ticated healthcare information network available through a free, statewide telephone number.

The new service, called Baptist Health, combines state-of-the-art computer and information access technology with a team of six specially-trained healthcare advisors who respond to individual healthcare needs through the telephone.

Baptist Health offers four distinct services that go beyond conventional hospital telephone information lines. They include: physician referral, educational opportunities, and a message library.

The services of Baptist Health are available free of charge by calling B-A-P-T-I-S-T (227-8478) in central Arkansas or 1-800-262-0054 statewide, 7 a.m. to 7 p.m. Monday through Friday. The system is also accessible 24-hours a day, seven days a week, through a special confidential phone line which allows a caller to leave a question or inquiry in a special voice mailbox and, through the use of a personal code, retrieve the recorded response to the question in complete privacy.

Voices of Experience

Fifty percent of older physicians would retire immediately or accelerate their retirement plans if health care is nationalized, according to a survey conducted by Merritt, Hawkins & Associates, a national physician search firm based in Irving, Texas.

The survey of 150 physicians aged 55 years old or older also revealed that aging physicians spend up to 10 times longer on government/insurer paperwork today than when they began practice, that about 40% of older physicians would not choose medicine as a career if they were starting today, and that over 60% would not recommend medicine as a career to their children.

The high level of professional discontent among older physicians sends a strong signal to health care reformers, according to Joseph Hawkins, CEO of Merritt, Hawkins & Associates.

"The American Medical Association reports that 29% of US physicians are 55 years old or older," Mr. Hawkins said. "Losing a large number of these experienced physicians to early retirement would be a serious blow to our health care manpower resources."

The wellspring of discontent for most older physicians is government and insurer related intervention and red tape, the survey indicated. Forty-five percent of physicians surveyed said that they and their staffs devoted an average of one to two hours a week on government/insurer paperwork during the first 10 years of their practice. By contrast, 59% of physicians responded that they and their staffs now devote 20 or more hours a week to government/insurer paperwork - a near 1000% increase in some cases. Seventy-six percent of physicians surveyed identified government intervention/insurer hassles as the single source of their greatest professional frustration. Twelve percent identified malpractice and 9% identified business pressures as the single source of their greatest professional frustration. Seventy-five percent of physicians surveyed responded that the practice of medicine had become less satisfying in the last five years.

The principal problem posed by early physician retirement for health providers is that physicians generally quit on impulse. Frequently, no succession plans are in place to ensure coverage for the physician's patients. Indeed, 59% of physicians surveyed indicated that they had made no plans to transfer their patients to another physician when they retired.

The survey of older physicians is conducted once every two years by Merritt, Hawkins & Associates and focuses on mostly primary care physicians located throughout the US. Compared with the results of two years ago, professional satisfaction among older physicians has declined slightly. Seven percent more physicians responding to the 1991 survey indicated that medicine has become less satisfying in the last five years than gave the same answer in 1989. Questions concerning nationalized health care and hours worked per week on government/insurer paperwork were new to this year's survey.

"One of the key lessons of this survey is that the US needs a health policy that will attract and keep the type of people best suited to be physicians," Mr. Hawkins said. "The best physicians are attracted to medicine by the special appeal of the physician/patient relationship. If that bond is supplanted by the physician/government relationship, many physicians will drop out of medicine. Patient care will be the loser."

FAMILY PRACTITIONER WANTED

South Central Arkansas, 2200 sq. ft. clinic, fully equipped. Liberal terms, no interest, will stay to introduce. Physician retiring. No OB. Rotate hospital coverage with other physicians. Send CV to:

Family Practitioner
PO Box 5776
Little Rock, Arkansas 72215-5776

Things To Come

June 26-28

Frontiers in Endourology. Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

June 29-July 3

Origins of Coping with Stress. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 6-10

Behavorial Medicine Applications. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 13-14

2nd Annual Meeting of the SAGM. Royal Garden Hotel, London, England. Sponsored by the Southern Association for Geriatric Medicine. For more information, call (205) 945-8425 or 1-800-423-4992.

July 13-17

Psychopharmacology Update. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 13-17

Multiple Family Group Therapy for Abuse. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 16-17

2nd Annual Meeting of the SAGM. Hotel Sofitel, Lyon, France. Sponsored by the Southern Association for Geriatric Medicine. For more information, call (205) 945-8425 or 1-800-423-4992.

July 20-24

Personality and Political Behavior. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 26-30

Current Concepts in Cardiology. Hyatt Regency Lake Tahoe, Incline Village, NV. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: to be announced. Category I credits available. For more information, call (916) 734-5390.

July 27-31

Learning Disorders in Childhood and Adolescence. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 3-7

Diagnosis and Treatment of Sexual Problems. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 3-7

Child Assessment and Psychotherapy. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 5-7

9th Annual Meeting of the SOA. Chateau Whistler Resort, Whistler, British Columbia. Sponsored by the Southern Orthopaedic Association. For more information, call (205) 945-1848 or 1-800-423-4992.

August 6-8

Clinical Allergy for the Practicing Physician. The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

August 10-14

Psychotherapeutic Intervention Following Head Injury. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 10-14

Treatment of Battering and Incest. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 13-15

5th Annual Meeting of the SAO. Westin Resort, Hilton Head Island, South Carolina. Sponsored by the Southern Association for Oncology. For more information, call (205) 942-0530 or 1-800-423-4992.

August 23-28

New Advances in Internal Medicine: Clinical Applications. Hyatt Regency, Monterey, CA. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: $480 physicians; $350 others; military discounts available. Category I and AAFP credits available. For more information, call (916) 734-5390.

August 24-28

Neuropsychological Assessment: New Directions. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

Psychoanalytic Theory and the Clinical Interchange. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

Leadership in an Era of Change. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), P.O. Box 5776, Little Rock, AR 72215-5776. Call the Society at (501) 224-8967 or 1-800-542-1058 for more information.

In Memoriam

Albert Martin Jr., M.D.

Dr. Albert Martin Jr., a retired family physician from Bella Vista, died Thursday, March 12, 1992. He was 80.

Dr. Martin was a member of the Arkansas Medical Society, the Benton County Medical Society, and a fellow in the American Academy of Family Physicians.

Survivors are his wife, Mary Martin of Bella Vista; two sons, A. Edward Martin III of Cody, WY and Richard W. Martin of Newton, KS; and five grandchildren.

S. Morris Young, M.D.

Dr. S. Morris Young, a general physician from Jonesboro, died Saturday, April 18, 1992.

Dr. Young was a member of the American Medical Association, the Arkansas Medical Society, and the Craighead/Poinsett Medical Society. He was the founder of the Medi-Quik clinics.

Dr. Young is survived by his wife, Elaine Young of Jonesboro; a stepson, John Frankel of Jonesboro; a stepdaughter, Hilary Frankel of Memphis, TN; his father, James Young Sr. of Clarksville, TN; and a brother, James Young Jr. of Clarksville, TN.

Keeping Up

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, every other Thursday, Sleep Disorders Center conference room. Lunch provided
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 12:00 noon, conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided. Category 1 credits available.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

MED-PAC
Arkansas Medical Society
Political Action Committee
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NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room

Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
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Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
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Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
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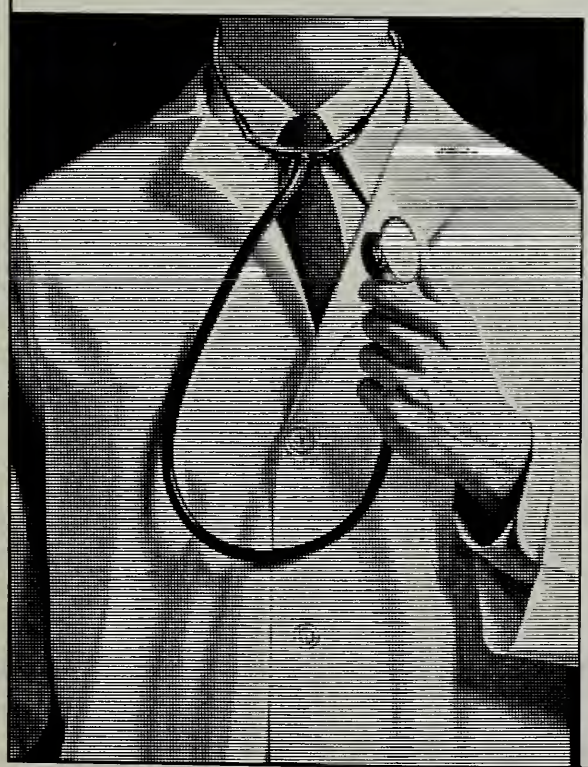

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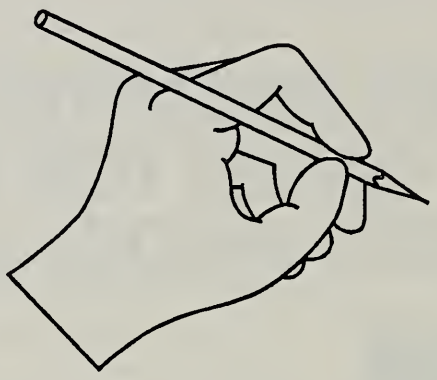

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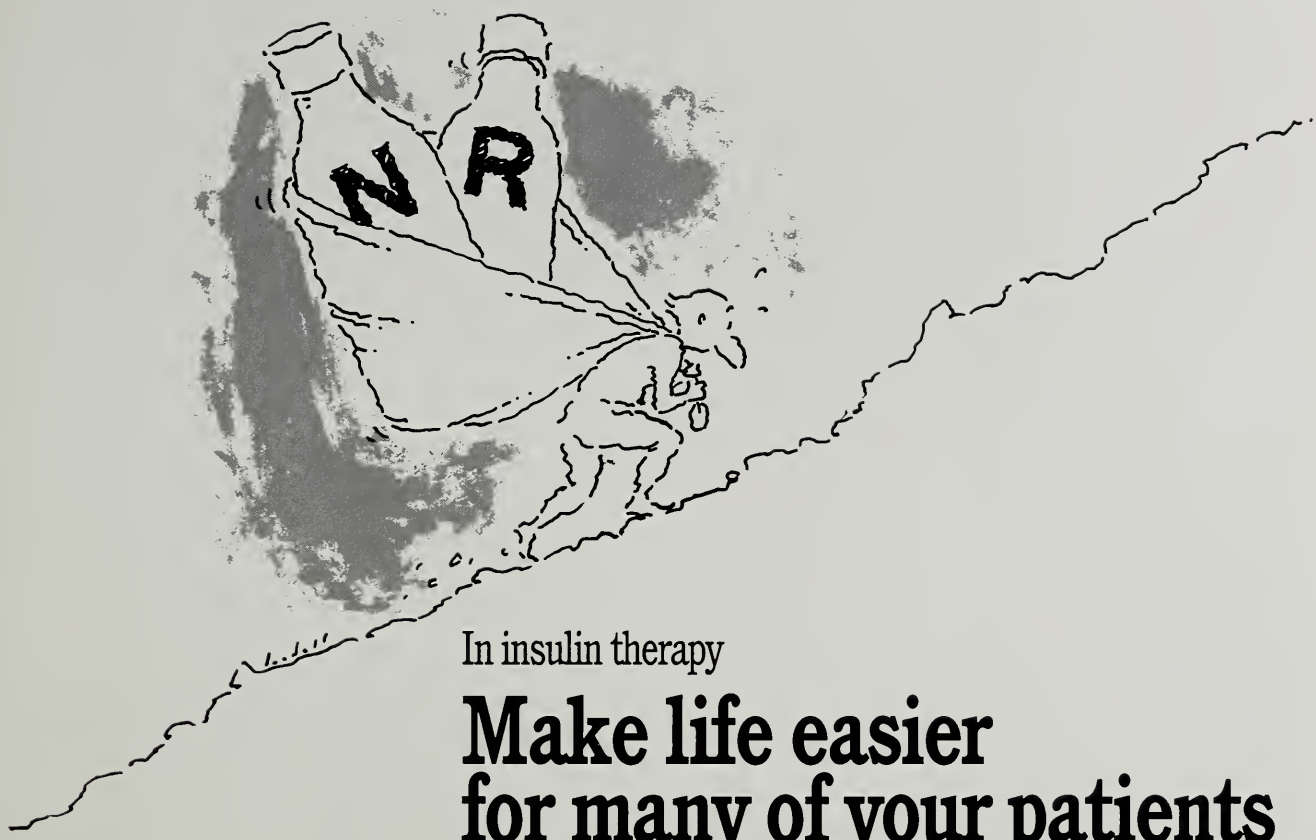

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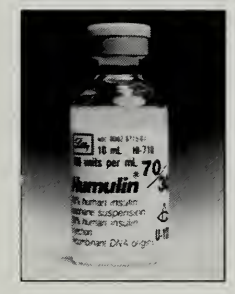

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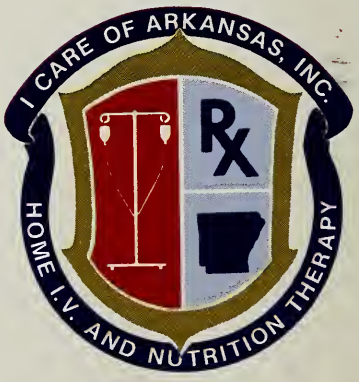

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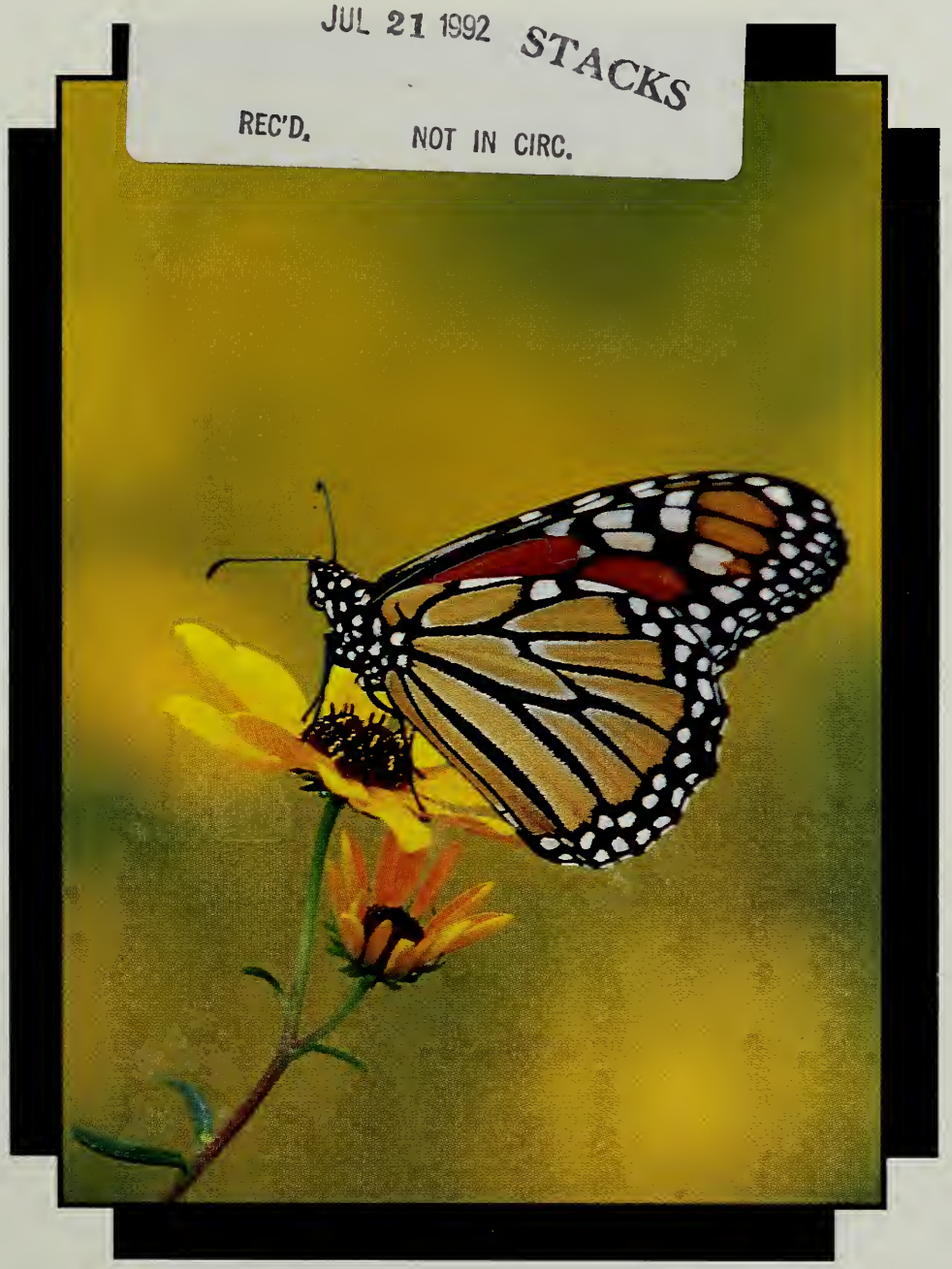

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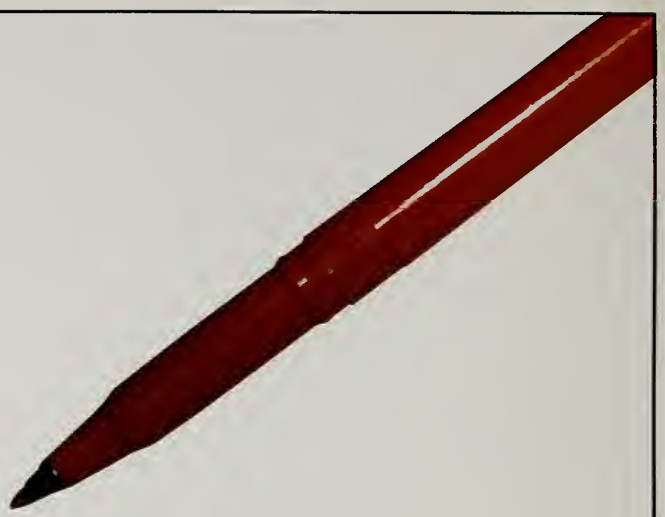

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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Cover photo was taken by AMS member M.C. Milligan, M.D., a retired physician from Pine Bluff.

Doctor Traps

Lee Abel, M.D.

There are a variety of traps that physicians may fall prey to. These pitfalls may be minor ones such as being asked by an acquaintance in a social situation for a medical opinion and being tempted to offer specific advice without really knowing all the details. Other traps are more a way of being that doctors adopt. These personality styles are often encouraged by a physician's rigorous training, the awesome responsibilities physicians assume, and sometimes by societal expectations.

A physician style that became so common it is not a stereotype, is the physician as an omniscient, God-like figure. This style seems at first be helpful to the physician by enhancing confidence and authority. However, it encourages the assumption of responsibility for things not truly under the doctor's control, and this may become a heavy burden to bear. Patients are often frightened and want unambiguous answers and reassurance. The authoritarian style tempts physicians to offer too much certainty and reassurance. This can foster unrealistic patient expectations and eventually lead to distrust and disillusionment if the physician is unable to deliver the hoped for outcome. I believe the physician as God stereotype is now relatively uncommon. The consumer movement has promoted the idea of physician and patient as partners working together to achieve better health, and most doctors embrace this style now.

Another trap that physicians may succumb to is that of materialism which, of course, is a temptation for many in our affluent society. When physicians get caught up in their practices as only "revenue producing businesses" and see acquiring possessions as their major goal, then we inevitably lose touch with our own humanity and the caring aspect of medicine. I think most physicians are able to enjoy the luxuries of life that come their way without being possessed by these possessions. Perhaps physicians are helped in not yielding to a materialistic mind set because in our offices we daily see the transient nature of things physical. Also, we are often privy to the troubles of very wealthy individuals who seem to have it all, but are less content than some of our patients of very modest means.

Another trap to which physicians are perhaps the most susceptible is that of perfectionism. This topic was recently the subject of an article in the American Medical News.[1] Perfectionism is usually thought of as a very desirable attribute for a physician, and not as something detrimental. Doctor Glen O. Gabbard, a psychiatrist at the Menninger Clinic, writes that perfectionism is "socially valuable, but personally expensive. Society's meat is the physician's poison." Perfectionists really believe they should not make any mistakes, and often hold themselves and others to this unrealistic goal. Making a lot of "should" statements also seems to be characteristic of the perfectionist. Studies have linked perfectionistic tendencies to a vulnerability to depression, self-doubt, obsessive worry, workaholism, interpersonal problems, and burnout. According to Dr. Mort Orman, a Baltimore, Maryland internist, "perfectionist tendencies underlie a lot of stress. If you suffer from stress, odds are good that perfectionism is playing a role." The problem is not the striving for excellence itself. The problem is "that some people beat themselves up" when they don't measure up to impossible standards, causing "agony and distress", according to psychologist Dr. Bruce Zahn

of the Presbyterian Medical Center in Philadelphia. When physicians are harshly critical of themselves for their perceived shortcomings, perfectionism may actually promote discouragement and poor performance.

The following is a copy of a quiz from the article that you might find interesting:

So You Think You're Not A Perfectionist?

1. Do you find that you're not satisfied with what you have accomplished? Do you suspect that others are doing more?
2. Do family members complain that you don't spend enough time with them?
3. Do you rarely enjoy leisure time or take a vacation?
4. If you make a mistake, do you tend to be severely self-critical?
5. Are you critical of others' behavior? Do you need other people to behave in certain ways?
6. Are you often depressed? Do you have trouble getting joy out of life?
7. When you find that you're not working as effectively as you could, do you stop and rest or work harder?
8. Do you tend to "expect the worst"? Do you often feel that any choice you make will turn out wrong?
9. Is it hard for you to leave work at the appointed hour?
10. When you see a journal you haven't read, do you feel guilty?

If you answered yes to any of the questions in this informal quiz, you may have perfectionistic tendencies. Perfectionism may help you in some situations but hurt you in others. If you answered more than a few of these questions affirmatively, watch out! Perfectionism may be having a negative impact on you and on people close to you.

The article also mentions that Dr. Orman has written a book "The Fourteen Day Stress Cure" (Breakthru Publishing, 1991). Perhaps I will pick up a copy to read. But first, I have decided I'm finally going to conquer that stack of journals sitting on my desk. I will go to bed one hour later each night until I have carefully read each one, underlining the important points, and neatly filing them in my article files. I really should, you know.

Reference

1. Skelly FJ, The Perils of Perfectionism. American Medical News, April 27, 1992, Vol. 35, No.16, pp. 33-35. ■

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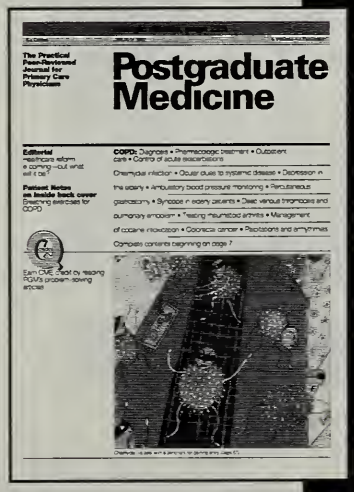

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Jo-Ann T. Bolli, M.D.*
Ann Maners, M.D.**

Current literature has conflicting reports as to the effect of age on prognosis in cancer of the uterine cervix. In order to evaluate this in our patient population we undertook a retrospective chart review of 235 cases of cervical cancer that were seen at the Central Arkansas Radiation Therapy Institute (CARTI) and the University of Arkansas for Medical Sciences (UAMS) from March 1974 to June 1985 and were followed for a minimum of 54 months. State, grade, and age greater than 70 years were significant predictors. Factors that were not statistically significant were race and morphology. Age less than 40, approached statistical significance as a predictive value. Our patients younger than age 40 had a tendency toward a slightly decreased survival when compared to those ages 40-60 and also a much decreased disease-free interval (50 months versus 97 months).

This paper was presented on October 25, 1990 at Student Research Day at UAMS.

Cervical cancer is the sixth most common cancer among women in the United States and is the second leading cause of gynecological cancer death (second only to cancer of the ovary). In 1989, approximately 240 Arkansas women were newly diagnosed with cervical cancer and only 44% are predicted to be alive in five years. While the rate of invasive carcinoma of the cervix has been steadily declining of the last few decades, thanks to the Papanicolaou smear, the rate of pre-invasive lesions has been steadily rising especially among the teenage population. In just our study, 44 women aged 30 or younger had cervical cancer and 22 died of it. These young women represented 20% of our cervical cancer patients!

The objective for this study was to evaluate the hypothesis that a young patient age at diagnosis of cervical cancer was a predictor of decreased five-year survival. In our patient population it appeared that the younger patient had a more aggressive form of this disease.

Materials and Methods

Patient Population: Two hundred and thirty-five cervical cancer patients who had their initial evaluation and diagnosis at the University Hospital were treated at CARTI from January 1976 through June 1985. These dates were chosen to allow a full five year follow-up. All of these patients have been followed and/or recently contacted either in person or through their personal physician. The patients were in all stages of the disease at diagnosis and their treatment was dependent on their clinical staging. The age range of our population was 22-99 years old. There were 122 whites and 97 blacks.

This initial cohort of UAMS patients was chosen so

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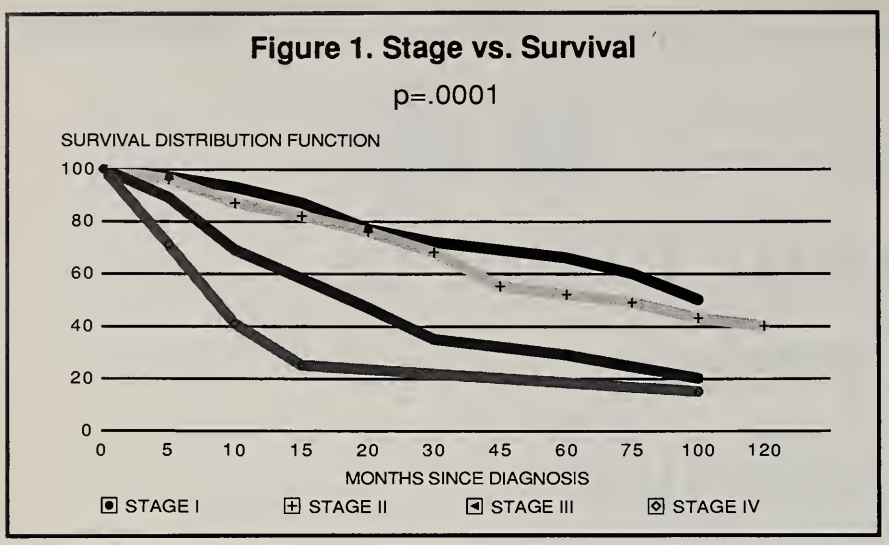


that we could evaluate our care at the University Hospital as compared to that of the state at large.

Statistical Methods: This study was a retrospective chart review. Data was gathered utilizing a self-designed data shell to elicit consistent information from each chart. The charts were reviewed for the pathology reports and tumors were classified into ICD-O codes and graded when possible. If a pathological grade was not available, the model illustrated by Buckley, Beards, and Fox[1] was used to assist in grading through a microscopic description of the tumor. The initial physical exam, either performed by the tumor board or the diagnosing physician, was reviewed to ensure accurate clinical staging according to the International Federation of Gynecology and Obstetrics (FIGO) standards and the Americal Joint Commission (AJC) guidelines in effect at the time of diagnosis. Extra diagnostic studies evaluated when available were: reports of chest x-ray, cystoscopy, proctosigmoidoscopy, IVP and surgical report of lymph node status.

The final radiation therapy treatment record was assessed for: total dosage, number of treatments, days elapsed during the treatment fractionation schedule, field delivered, energy level/source, and implant record for milligram-hour radium equivalents. The progress notes and reports from outside physicians were utilized to assess for short and long-term radiation therapy side-effects.

An independent statistician was hired by CARTI to evaluate the date using the SAS/Lifetest model with special emphasis on actuarial survival using age-adjustment tables and regression analysis. Data was initially evaluated for trends using univariate analysis and corrections made to adjust for stage and tumor grade effects on survival. Statistical significance was evaluated by Chi Square.

Results

The final number of patients was 219 due to a lost of 16 patients that were classified as "loss to follow," meaning that we were unable to contact them before a total of 54 months had elapsed from diagnosis to loss. We used 54 months as the cutoff, for if these patients showed no evidence of disease at 54 months and 95% of recurrences happen within the first two years, it would be statistically unlikely that these women would die of cervical cancer within the next six months. The overall five-year survival of the group was 44% (96/219) but only 32% (70/219) survived five years without disease (NED). The FIGO Annual Report of 1976-1978[2] concerning cervical cancer patients showed a 55% absolute five-year survival illustrating that we did not fare as well.

RACE: There were 44% black and 55% whites entered into our study. The normal population distribution of blacks in Arkansas in 1980 was 16.3%, therefore, this subset of patients is heavily weighted with blacks. This is not a true percentage of the incidence of cervical cancer in the black population, but merely a skewed population due to the patient population served at University Hospital during that time period. However, the literature does not report a higher incidence of cervical cancer in the black population (almost double that of whites).

When we compared survival for black and white populations, we found no statistical difference (p=0.14), but at 30 months there was a logarithmic divergence in survival. We do not have an explanation for this phenomenon.

STAGE: The stage at presentation (Table 1) was assessed and our data closely correlates with the National averages reported in the same FIGO Annual Report.[2]

Table 1. Stage at Presentation

	UAMS	FIGO
STAGE I	31%	34.9%
STAGE II	34%	33%
STAGE III	26%	27%
STAGE IV	8%	5%

Good correlation exists between the national averages and the Arkansas population.

Analysis for survival at different stages was performed and this proved to be the most potent predictor of five-year survival (p=0.0001) which is consistent with that already published in the literature. However, we found that Stages I and II acted alike with a better prognosis, and Stages III and IV acted similar in a worse prognosis (Figure 1). We feel that this perhaps reflects the subgroup of Stage I which is predominantly treated

with radiation therapy, i.e. that group having a larger tumor burden.

Compared to national statistics, we have a moderate decrease in survival at all stages except for Stage IV (Table 2), but this is well within the range of normal variation reported in many different studies.

Table 2. Stage Survival

	UAMS	FIGO
STAGE I	67%	78%
STAGE II	52%	57%
STAGE III	29%	31%
STAGE IV	17%	8%

UAMS has a slight decrease in survival of all stages except Stage IV.

MORPHOLOGY: Pathologically, carcinoma of the cervix has many different morphologic term. In order to evaluate morphologic behavior, due to small numbers assigned to each term, we found it necessary to group like cytologies. We decided on three different groups for analysis: A) the Squamous cell carcinoma group (192); B) the Adenocarcinoma group (24); and C) the microinvasive group.[3] Eighty-seven percent (192/219) of our tumors were squamous-type which is similar to the 90% reported by FIGO.[2] There were only three cases of microinvasive carcinoma and therefore, none of the analysis done with it could be regarded as statistically significant.

Morphology did not prove to have any statistical significance with respect to survival (p=0.98). However, this does not compare with the literature in that much of it reports a worse prognosis with the adenocarcinoma-type tumor. Currently, we have no explanation for this behavior.

GRADE: Thirty-seven percent (82/219) of all tumors were not graded. Some in our study were able to be categorized, based on a paper by Buckley, Beards & Fox,[1] if there was a pathological microscopic description that fit these criteria. However, most of the ungraded pathology reports merely had a pathological diagnosis attached without a microscopic description. Almost 52% (71/219) of our known-grade tumors were poorly differentiated which is more than Dattoli reports.[4] The poorly differentiated tumors had no apparent groupings, i.e age, stage or morphology.

In the literature, grade is not generally felt to be a predictor of differential outcome. However, in our study it turned out to be statistically significant (p=0.01). We found that grades three and four were associated with a poor outcome. This is consistent with a paper published in 1983 by Prempree[4] and another by Bloom in 1965.[5]

AGE: The mean age at diagnosis was 53 years as compared to the FIGO Report[2] with a mean of 54 years. There were more patients less than 40 in our study than that reported [21.5% (47/219) vs 16%], but less in the 60-70 age group [18% (39/219) vs 22%].

We found that age greater than 70 was a significant predictor of a poor survival (p=.0002). However, please note the line which represents the less than 40 age group (figure 2). Even though they survive better than the age greater than 70 group, they fare worse than those from 40-70. Statistical multivariate analysis indicated that those patients less than 40 years and those older than 70 tended to act alike (a young/old grouping) in regards to survival, whereas, those between the ages of 40-60 (middle age grouping) were alike in their better prognosis and very different from the young/old group (p=.07). Although not considered statistically significant, it approaches it. This is in agreement with the data reported in the same FIGO Report.[2]

Multivariate analysis using our parameters of race, stage, morphology, grade, and age when evaluated comparing five-year survival showed no statistical differences between our groups. That is, all parameters were essentially equal in all age groups and there is nothing as yet found to explain the differences in survival in these age groups.

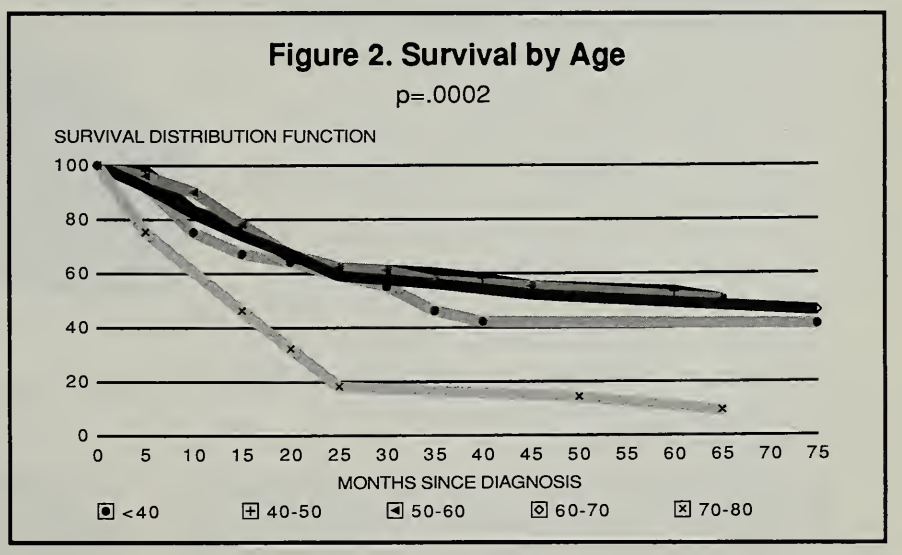
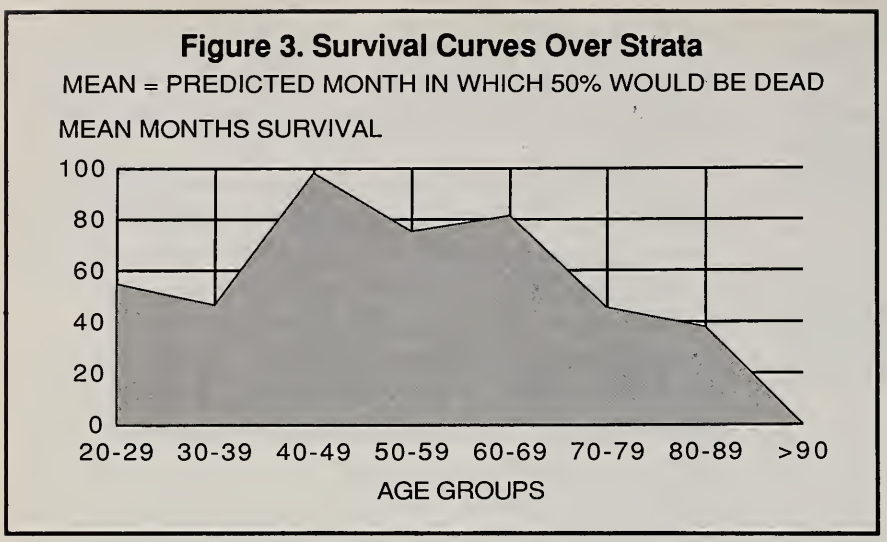


Figure 3 illustrates an analysis of the mean survival of each age group. This is the analogical equivalent to the Ld_{50} (lethal dose), where it is the predicted month in which only 50% of that age group will be alive. Those age 40-50 live a mean of 97 months while those less than 40 are living a mean of 50 months. We found this fact to be unsettling.



We then compared our different age groups in analysis for five year survival with no evidence of disease (NED) (figure 4). As expected, survival was poor for those greater than age 70. However, note the dip in the curve before age forty. Less survive five years without disease. One would have anticipated this to be a down-sloping curve or at least a plateau where those less than 40 would fare just as well, if not better, than those 40 and older.

Discussion

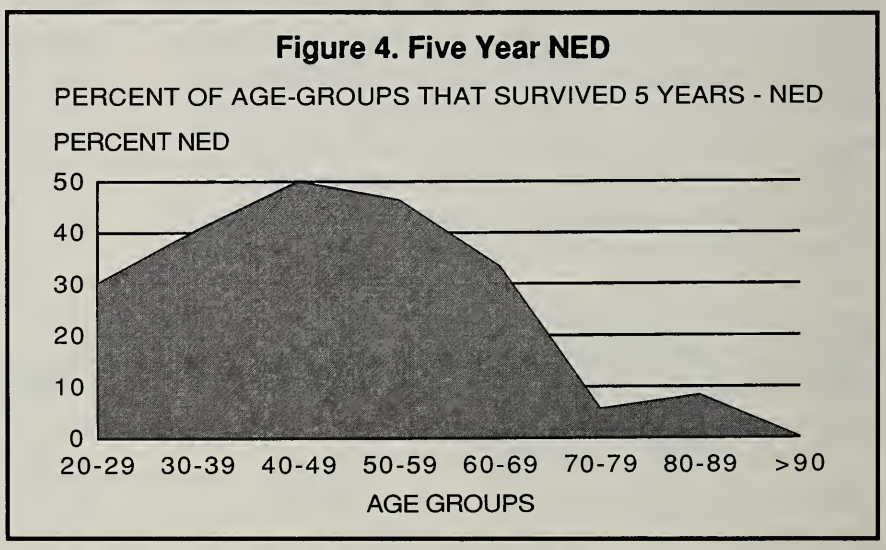
The controversy concerning age as a prognostic factor in carcinoma of the uterine cervix stems back to an article published in 1952 by Lindell.[6] This investigation discovered that five-year survival improved with increasing age for all stages of the disease. A study in 1955, by Decker et al, of the Mayo Clinic, attempted to reproduce Lindell's statistics and actually found no significant difference in stage-grouped survival for patients under age 35 versus those over 35.[7]

The issue remained relatively dormant in the literature with an occasional article or two appearing periodically but none in particular settling the argument.

In 1980, an article entitled, "Carcinoma of the Cervix: the Effects of Age on Survival" by Stanhope et al again brought the issue to light.[8] This article examined 265 patients and they found a highly significant difference in age-divided survival ($p < 0.005$) for Stages IB, IIA, IIB, and III with patients younger than 35 years having the worse prognosis. They were unable to suggest a cause for this difference. Although histology was suspected as the cause, it led to no real conclusion.

An excellent paper surfaced in 1988 by Buckley, Beards and Fox which may at least partially provide a clue to the cause.[1] They retroactively examined pathologically 246 cases of cervical cancer utilized newer staining methods (not previously available or routinely used at the time of diagnosis) and reclassified the tumors histologically with an improved, defined grading system. It has been established that lymph node metastasis is an important predictor of death and recurrence. Buckley's study found that this occurred more often with mucous secreting carcinomas and those with vascular invasion. They found that these predictors of lymph node metastases were more prevalent in women under the age of 40 in what appeared clinically to be early stage disease.

There are several large studies that illustrate both sides of the issue. Stanhope,[8] Gynning,[9] Prempree,[4] and Dattoli[3] all found a decreased survival; while Meanwell,[10] Russell,[11] and Junor[12] all shoe an increased five-year survival. It is interesting to note however, that Meanwell, Russell, and Junor are all British reports. Perhaps there are other disease factors occurring in the British population, or statistical analysis methods utilized that might explain the difference. However, do note that Buckley's experimental population is also British.



In summary, our study found that stage, grade, and age greater than 70 are significant predictors of outcome in our patients with carcinoma of the cervix. Those factors that were not significant were: race and morphology. Even though absolute five-year survival was not statistically significant, we felt that there is a tendency in our patient population toward a decreased survival and a decreased disease-free interval in the younger women die continues to be distressing and we will continue to seek out the explanations for this. In the meantime, this underscores the need for heightened

vigilance in younger patients with regards to screening techniques and possibly more aggressive therapy for pre-invasive lesions.

References

1. Buckley CH, Beards CS, Fox H. Pathological prognostic indicators in cervical cancer with particular reference to patients under the age of 40 years. Brit J Obstet Gynecol, 1988; 95:47-56.

2. Pettersson F, Kolstad P, Ludwig H, Ulfelder H, eds. Annual Report of the Results of Treatment in Gynecological Cancer Vol. 19. Results obtained from 1976 to 1978 inclusive. Published by FIGO Editorial Committee. FIGO Annual Report.

3. Dattoli MJ, Gretz III HF, Beller U, Lerch BA, Demopoulos RI, Beckman EM, Fried PR. Analysis of multiple prognostic factors in patients with state IB cervical cancer: age as a major determinant. Int J Radiat Oncol Biol Phys, 1989; 17(1):41-47.

4. Prempree T, Patanaphan V, Sewchand W, Scott RM. The influence of patient's age and tumor grade on the prognosis of carcinoma of the cervix. Cancer, 1983; 51(9):1764-1771.

5. Bloom HJG. The influence of tumor grade on radiotherapy results. Brit J Radiol, 1965; 38:(447):227-240.

6. Lindell A. Carcinoma of the uterine cervix: incidence and influence of age: a statistical study. Acta Radiol; 1952; 92(suppl):1-102.

7. Decker DG, Frikce RE, Pratt JH. Invasive carcinoma of the cervix in young women. JAMA, 1955; 158:1417-1420.

8. Stanhope CR, Smith JP, Wharton JT, Rutledge FN, Flecther GH, Gallagher HS. Carcinoma of the cervix: the effect of age on survival. Gynecol Oncol, 1980; 10:188-193.

9. Gynning I, Johnson JE, Alm P, Trope C. Age and prognosis in stage IB squamous cell carcinoma of the uterine cervix. Gynecol Oncol, 1983; 15:18-26.

10. Meanwell CA, Kelly KA, Wilson S, Roginski C, Woodhan C, Griffiths R, Blackledge G. Young age as a prognostic factor in cervical cancer: analysis of population based data from 10,022 cases. Brit Med J, 1988; 296:386-391.

11. Russell JM, Blair V, Hunter RD. Cervical carcinoma: prognosis in younger patients. Brit Med J, 1987; 295:300-303.

12. Junor EJ, Symonds RP, Watson ER, Lamont DW. Survival of younger cervical carcinoma patients treated by radical radiotherapy in the west of Scotland 1964-1984. Brit J Obstet Gynecol, 1989; 95(5):522-528. ■

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Tobacco - Masters of Misinformation

A four-color brochure, published and widely distributed by the Tobacco Institute, tells employers to beware of smoke-free work environments or suffer the consequences of reduced productivity.

Such misstatements - supposedly validated by statistical research from organizations with official sounding names - will fill the airways and the newspapers in Arkansas as a result of efforts to add a 25-cent tax to each package of cigarettes.

CHAR, or Coalition for a Healthier Arkansas, was formed earlier this year primarily through the efforts of the Arkansas Medical Society and William N. Jones, M.D., past president of the AMS. Since its inception and public announcement in late March, CHAR has grown like Topsy and now encompasses almost 50 different statewide organizations.

According to Dr. Jones, CHAR planned on delivering more than the required 55,000 signatures to the offices of the Secretary of State by July 3, the cutoff date, which puts the initiative on the ballot in Arkansas on November 3.

If enacted, the tax revenue would raise $68 million annually. Half of the money would be designated as federal matching funds - a three to one match - providing treatment and care to Medicaid patients.

Other funds would be earmarked for senior citizen services, education for young people on the abuse of drugs, alcohol and tobacco, aid to families and abused children and to fund cancer research in Arkansas.

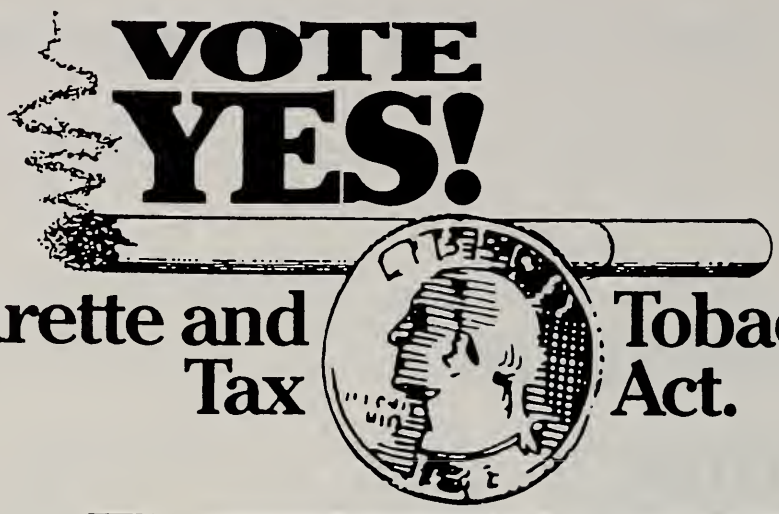
But what can we expect from the opposition now that the issue appears to be headed for the November ballot? If past journalistic practices are any indicator, misstatements based on distorted facts will set the tone of the multi-million dollar efforts in Arkansas from the Big Tobacco companies and the Tobacco Institute.

One thing to expect early in the campaign is the formation of so-called grass root anti-tax groups. Although these Anti-tax groups will never admit it, a trail of checks and bank deposits may lead back East to powerful and wealthy interests who are concerned more with profits than with taxes being used to treat older folks whose bodies have been ravaged by years of nicotine addiction.

Another ploy to expect from these same high powered folks directing efforts from Raleigh, Winston-Salem and even Washington will be TV and radio advertising support totally ignoring the truth about CHAR and its membership. In other states and in Canada where efforts similar to the one in Arkansas have already taken place, false accusations became the standard fare to obtain news space on TV and in the daily papers.

"We fully expect tobacco to assail the medical community by accusing us of greed and avarice in our attempts to get this ballot initiative made into law," according to Dr. Jones. "But we won't be the only ones being accused. Since the coalition includes practically every major health provider group in the state, we can assume all of us will be targets of their abusive statements in the media."

"We know they have hired a local political consultant



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and a media expert to work for them. We're expecting an announcement regarding which of the larger advertising agencies will be handling their account locally. In addition, we thing they'll be using at least two or three national firms who have had experience in fighting health groups like CHAR in California and Montana," Dr. Jones concluded.

At one time this Spring, it was thought there would be cigarette tax increases on the ballot in five or six states. Since then, the tobacco companies - through legal maneuverings - have kept the tax increase from appearing on the November ballot in Oregon and delayed the ballot initiative until 1993 in Colorado.

Who knows what kinds of legal tactics or factual misrepresentations will be forthcoming in Arkansas?

Whatever they are, expect them to hit low, hard and with unlimited financial resources. It may be a long, hot and sweaty summer for CHAR and for health-conscious voters in the Natural State. ■

COALITION FOR A HEALTHIER ARKANSAS

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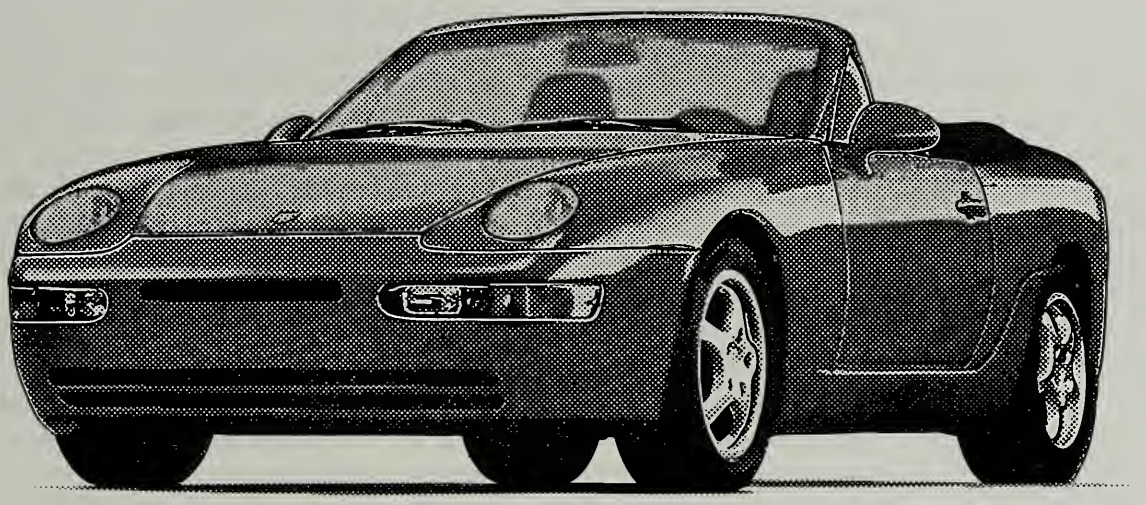

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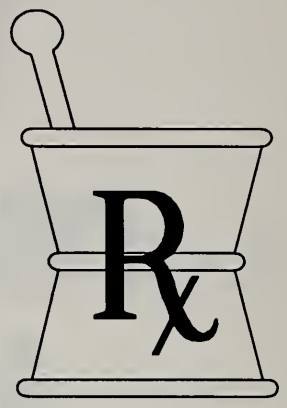

Lester Hosto, P.D.*

As a result of federal legislation, the Arkansas State Board of Pharmacy has adopted Regulation #48 regarding patient counseling. Reprinted below is the information that was provided to every Arkansas pharmacist by Dr. Hosto of the Arkansas State Board of Pharmacy.

Dear Pharmacist:

The Board of Pharmacy has adopted this regulation to require that Arkansas Pharmacists provide a minimal level of patient care in the areas of monitoring medications and educating patients about their medication to improve patient care and compliance.

The regulation is now in effect, and I have received several comments that physicians want to know more about the effort and that physicians are especially interested in the drug interaction list.

More than three years ago, the idea was conceived that pharmacy must be practiced more consistent with the way we are educated and trained to practice. A committee, representing all aspects of pharmacy practice, started meeting in an attempt to plan how this could be accomplished.

The process involved the Board of Pharmacy, the Arkansas Pharmacist Association, pharmacy leaders from every area, presentations at district meetings, a drug interaction and side effects committee, legislation, public hearings, and legislative review.

Regulation #48 and the list of most critical and injectable drug interactions have been adopted. The collection of patient information started July 1, 1991; and the monitoring and patient counseling parts started January 1, 1992. Much has been written about this in our Board Newsletter. Regulation #48 was printed in the November 1990 issue.

I suggest that you finalize the collection of patient information for regular patients and begin the monitoring for interactions, overuse, underuse, duplication of therapy, etc.

Regarding drug interaction, you will need information such as Facts Drug Interactions, Hanstens, computer software, etc., to explain the interaction when asked by the physician. If you have problems in this area, please call me.

When monitoring, if you find a problem or a side effect that must be addressed, please don't be confrontational or challenging to the physician. Just call the physician, explain that you are required to monitor for certain problems, that you have detected a problem, and that you are required to bring it to his/her attention. If the physician's decision concerns you, I suggest you make a note on the prescription that you explained your concerns to the physicians. If you strongly disagree with the physician, it is your right to refuse to provide the medication; but this should be in very isolated instances.

Sincerely,

Lester Hosto, P.D.
Executive Director

* Dr. Hosto is executive director of the Arkansas State Board of Pharmacy in Little Rock.

Regulation #48: Patient Information, Drug Use Evaluation, and Patient Counseling

The intent of this regulation is to improve pharmaceutical care by defining basic standards of care. Pharmacy care/ pharmaceutical care is defined as the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. These outcomes are: 1) cure of disease; 2) elimination or reduction of a patient's symptomatology; 3) arresting or slowing a disease process; or 4) preventing a disease or symptomatology.

Pharmaceutical care (clinical pharmacy) involves four major functions on behalf of the patient: 1) identifying potential and actual drug-related problems; 2) resolving actual drug-related problems; 3) preventing potential drug-related problems; and 4) optimizing patient therapy outcomes. It is recognized that the patient might be best served if medication is not provided.

SECTION I: Patient Information (Profile)

In order to effectively counsel patients, the pharmacist must, through communication with the patient or caregiver, make a reasonable effort to obtain, record, and maintain the following information for each patient. It is recognized that most of this can be obtained using "qualified pharmacy employees" and designed forms, etc.

A. Name, Address, Telephone Number;
B. Date of Birth (Age), Gender;
C. Medical History
   1. Significant patient health problems known to the pharmacist.
   2. Prescription drug reactions/prescription drug allergies.
   3. List of prescription medications and legend drug administration devices known to the pharmacist.
D. Transitory patients or situations where the pharmacy will only provide medication one time—in obtaining patient information, if the pharmacist knows or is informed by the patient that this is a one-time situation, the pharmacist may forego the above requirement to record and maintain the information.
E. Pharmacist comments.

SECTION II: Drug use Evaluation—For New and Refill Prescriptions

Drug use evaluation or drug utilization review includes the following activities:

A. The pharmacist shall evaluate the prescription or medication order for:
   1. Reasonable dose and route of administration.
   2. Reasonable directions for use.
B. The pharmacist shall evaluate medication orders and patient information for:
   1. Duplication of therapy - is the patient taking same or similar medication(s).
   2. Prescription drug-prescription drug interactions as listed in the Board of Pharmacy's "List of Significant Drug Interactions" (see section IV).
   3. Proper utilization (over or under utilization).
   4. Known drug allergies.
   5. Drug-Drug Contraindications as defined by the Board. (Is this medication contraindicated with another medication the patient is taking?)

It is recognized that the ultimate decision to use the medication or not use the medication rests with the physician who has more complete patient information. It is the pharmacist's responsibility to monitor the patient's medication therapy in the areas addressed in this regulation and inform the physician of the suspected problem.

If a problem is suspected and the physician is informed, the pharmacist shall document the process.

SECTION III: Patient Counseling

- A pharmacist shall counsel the patient or caregiver "face to face" if the patient or caregiver is in the pharmacy. If not, a pharmacist shall make a reasonable effort to counsel the patient or caregiver;
- Alternative forms of patient information may be used to supplement, but not replace face to face patient counseling;
- Patient counseling, as described herein, shall also be required for outpatients of hospitals and institutions when medications are dispensed on discharge from the hospital or institution.
- Patient counseling as described in this Regulation shall not be required for inpatients of a hospital or institution where a nurse or other licensed health care professional is authorized to administer the medication. However, the pharmacist shall provide drug therapy counseling when professionally deemed to be appropriate and when medications

are provided by the pharmacy, when a pharmacist is on duty and a patient is discharged from the hospital or institution.

- The pharmacist shall maintain and make available to all patients appropriate patient-oriented reference materials USP-DI or Facts and Comparisons Patient Drug Facts or an equivalent or better as determined by the Board.
- It is recognized that the ultimate decision to not provide patient counseling rests with the physician. If the physician in specific instances (blanket requests not accepted) requests that information NOT be provided to the patient and gives reason, the pharmacist should honor that request in almost all instances.

"Patient Counseling" shall mean the effective communication by the pharmacist of information, as defined in this act to the patient or caregiver, in order to improve therapeutic outcome by encouraging proper use of prescription medications and drug delivery devices.

1) For original prescription medication orders, (excluding renewed or updated prescriptions the patient has been recently taking) and orders for legend devices specific areas of counseling shall include:
   a) Name and general description of the medication dispensed, i.e. antibiotic, antihistamine, blood pressure medicine, etc;
   b) Name, general description and directions for use of drug delivery devices, i.e., insulin syringes, morphine pump, etc;
   c) Explain route of administration, dosage, times of administration, and continuity of therapy;
   d) Special directions for storage as deemed necessary by the pharmacist;
   e) If the drug has been determined to have a significant side effect by the Board of Pharmacy and is on the Board of Pharmacy's "List of Drugs With Significant Side Effects," (see Section IV) the patient shall be properly counseled to the extent deemed necessary by the pharmacist;
   f) When the prescription drug dispensed is on the "List of Significant Drug Interactions" if taken with OTC drugs, the pharmacist should counsel the patient about that interaction. (Example: Coumadin with Aspirin);
   g) If the prescription medication is significantly affected by food or diet the pharmacist should so advise the patient. (Example: Tetracycline with milk or food);
   h) The pharmacist shall inform the patient or caregiver that he/she is available to answer questions about medications or general health information.
2) Refills—On refills the pharmacist shall present the opportunity for the patient or caregiver to ask questions. However, counseling on refills is not required except when needed in the professional judgement of the pharmacist.

SECTION IV: Drug Interactions—Significant Side Effects

Recognizing that a pharmacist cannot be expected to recognize all possible drug interactions and also recognizing that the pharmacist and the patient does not have time to explain the numerous of side effects of drugs, the Board of Pharmacy shall determine and provide the following:

1) <u>List of Significant Drug Interactions</u>
   These are known and documented drug interactions which require specific monitoring to optimize therapy and/or prevent adverse effects

2) <u>List of Drugs With Significant Side Effects</u>
   These are drugs with side effects which may be managed most effectively if the patient is aware of the specific side effect and what to do if it occurs.

The Board of Pharmacy shall develop and update these lists and the pharmacist will only be responsible for the current lists as provided by the Board.

INJECTABLE DRUG INTERACTIONS

Aminoglycosides, parenteral/loop diuretics, amikacin, gentamicin, kanamycin, neomycin netilmicin, streptomycin, tobramycin, bumetanide, ethacrynic acid, furosemide
Anticoagulants/cephalosporins, parenteral warfarin, cefamandole, cefoperazone, cefotetan, moxalactam
Carmustine/cimetidine
Dopamine/phenytoin, parenteral
Epinephrine/carteolol, nadolol, pindolol, propranolol, timolol
Lidocaine I.V./atenolol, metoprolol, nadolol pindolol, propranolol
Lidocaine I.V./cimetidine
Lidocaine I.V./ranitidine

MOST CRITICAL DRUG INTERACTIONS

ACE Inhibitors/Potassium Sparing Diuretics
Allopurinol/azathioprine
Allopurinol/mercaptopurine
Anticoagulants/allopurinol
Anticoagulants/amiodarone
Anticoagulants/anabolic steroids
Anticoagulants/aspirin—salicylates
Anticoagulants/barbiturates
Anticoagulants/carbamazepine
Anticoagulants/chloral hydrate
Anticoagulants/cholestyramine
Anticoagulants/cimetidine
Anticoagulants/ciprofloxacin
Anticoagulants/clofibrate
Anticoagulants/colestipol
Anticoagulants/danazol
Anticoagulants/dextrothyroxine
Anticoagulants/diflunisal
Anticoagulants/disulfiram
Anticoagulants/erythromycin
Anticoagulants/ethchlorvynol
Anticoagulants/fenoprofen
Anticoagulants/gemfibrozil
Anticoagulants/gluthemide
Anticoagulants/griseofulvin
Anticoagulants/hydantoins
Anticoagulants/indomethacin
Anticoagulants/mefenamic acid
Anticoagulants/metronidazole
Anticoagulants/nalidixic acid
Anticoagulants/oral contraceptives
Anticoagulants/phenylbutazone
Anticoagulants/primidone
Anticoagulants/quinidine—quinine derivatives
Anticoagulants/ranitidine
Anticoagulants/rifampin
Anticoagulants/sulfinpyrazone
Anticoagulants/sulfonamides
Anticoagulants/sulindac
Anticoagulants/thyroid hormones
Anticoagulants/vitamin K
Antidiabetic agents/beta-blockers
Barbiturates/CNS depressants
Beta-blockers/Verapamil
Carbamazepine/cimetidine
Carbamazepine/danazol
Carbamazepine/diltiazem
Carbamazepine/erythromycin
Carbamazepine/isoniazid
Carbamazepine/propoxyphene
Carbamazepine/verapamil
Cyclosporine/cimetidine
Cyclosporine/digoxin
Cyclosporine/diltiazem
Cyclosporine/erythromycin
Cyclosporine/hydantoin anticonvulsants
Cyclosporine/ketoconazole
Digitalis glycosides/cholestyramine
Digitalis glycosides/colestipol
Digitalis glycosides/cordarone
Digitalis glycosides/diltiazem
Digitalis glycosides/erythromycin
Digitalis glycosides/potassium-depleting diuretics
Digitalis glycosides/propafenone
Digitalis glycosides/quinidine
Digitalis glycosides/quinine
Digitalis glycosides/tetracycline
Digitalis glycosides/verapamil
Fluoxetine/tricyclic antidepressants
Hydantoin anticonvulsants/amiodarone
Hydantoin anticonvulsants/chloramphenicol
Hydantoin anticonvulsants/cimetidine
Hydantoin anticonvulsants/disulfiram
Hydantoin anticonvulsants/isoniazid
Hydantoin anticonvulsants/phenylbutazone
Hydantoin anticonvulsants/sulfonamides
Insulin/timolol
Insulin/carteolol
Insulin/nadolol
Insulin/propranolol
Insulin/labetalol
Insulin/pindolol
Isoniazid/rifampin
Lithium/diuretics
Lithium/NSAIDs
Lovastatine/gemfibrozil
MAO inhibitors/amphetamines
MAO inhibitors/buspirone
MAO inhibitors/carbamazepine
MAO inhibitors/cocaine
MAO inhibitors/dextromethorphan
MAO inhibitors/ephedrine
MAO inhibitors/fluoxetine
MAO inhibitors/guanadrel
MAO inhibitors/levodopa
MAO inhibitors/MAO Inhibitors
MAO inhibitors/meperidine
MAO inhibitors/methyldopa
MAO inhibitors/methylphenidate
MAO inhibitors/phenylephrine
MAO inhibitors/pseudoephedrine
MAO inhibitors/guanethidine
MAO inhibitors/rauwolfia alkaloids
Methotrexate/probenecid
Methotrexate/salicylates
Methotrexate/sulfonamides
Oral contraceptives/barbiturates
Oral contraceptives/hydantoins
Phenobarbital/valproic acid
Potassium/potassium-sparing diuretics
Quinidine/amiodarone
Quinidine/phenobarbital
Tricyclic antidepressants/clonidine
Tricyclic antidepressants/ephredrine
Tricyclic antidepressants/guanethidine
Tricyclic antidepressants/phenylephrine
Tricyclic antidepressants/phenylpropanolamine
Tricyclic antidepressants/pseudoephedrine
Xanthines (except dyphylline)/cimetidine
Xanthines (except dyphylline)/ciprofloxacin
Xanthines (except dyphylline)/erythromycin
Xanthines (except dyphylline)/hydantoin
Xanthines (except dyphylline)/ofloxacin
Xanthines (except dyphylline)/norfloxacin
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Xanthines (except dyphylline)/timolol
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What the Americans with Disabilities Act Means to the Doctor's Office

David L. Ivers, J.D.*

Have you installed wheelchair ramps at your office? Widened doors? Lowered counters? Installed flashing alarm lights? Removed high pile carpeting? Made curb cuts in sidewalks?

If not, then you may be violating the Americans with Disabilities Act,[1] the most significant civil rights legislation since the landmark Civil Rights Act of 1964.

The ADA means great changes for almost every area of society, including doctors' offices. It offers the hope of integration and equal access for 43 million Americans with disabilities. However, the Act is so sweeping and complex that many physicians with good intentions don't know where to begin in order to comply.

Much has been written about Title I of the ADA, which prohibits discrimination in employment based on disabilities. But much less is known about Title III of the act, which could have even greater impact. Title III requires removal of many of the structural and service barriers that people with disabilities face in places of public accommodation. Almost every business that serves the public is considered a public accommodation. This article outlines the requirements of Title III as they apply to doctors' offices.

For most purposes, Title III went into effect on January 26, 1992. For offices with 25 or fewer employees and gross receipts of $1 million or less, the effective date is July 26, 1992, and for offices with 10 or fewer employees and gross receipts of $500,000 or less, the date is January 26, 1993.

Existing Buildings

The good news for many doctors is that the ADA is more flexible when it comes to existing buildings, as opposed to new construction or alterations. In existing buildings, the key is "readily achievable." A barrier does not have to be removed if doing so would not be readily achievable, which is defined as that which is "easily accomplishable and able to be carried out without much difficulty or expense."

To aid in deciding what is readily achievable, the act lists several factors to consider, including the nature and cost of the action needed; the overall financial resources of your office; the number of people employed; and the effect such actions would have on expenses, resources and other aspects of your practice. For example, the ADA regulations[2] make it clear that if providing wheelchair access to a bathroom means giving up an examining room, then the change is not readily achievable.

However, even if a certain change is not readily achievable, the act requires that you accommodate disabled persons through other methods if such methods are readily achievable. Alternatives could include such measures as providing home delivery or relocating examining equipment to accessible rooms.

* Mr. Ivers is an associate with Mitchell, Blackstock & Simmons in Little Rock, general counsel for the Arkansas Medical Society.

Alterations

The standards are much higher for alterations and new construction. An alteration is not defined precisely, but basically it means renovation, remodeling or structural changes that affect the way people use the building and not simple cosmetic changes or routine maintenance.

Any alteration that began after January 26, 1992, must comply to the "maximum extent feasible." Feasibility here refers to technical feasibility, not financial. Thus, according to the regulations, the only exceptions will be the "occasional case" where the nature of the building makes it "virtually impossible." And even then, you must comply to the extent possible. Also, alterations in certain areas impose a duty to ensure that the entrances, rest rooms, telephones, and drinking fountains serving those areas are accessible.

New Construction

New construction refers to buildings that will be occupied after January 26, 1993. They must be "readily accessible to and usable by individuals with disabilities." This means that the only exception to providing complete access is those rare cases when it is "structurally impracticable." And even then you must comply to the extent not structurally impracticable. The standards for new construction and alterations cover employee areas of your office as well, not just patient areas.

Whether your practice is concerned with removing barriers, making alterations or constructing a new building, the regulations call for compliance with a detailed set of standards called the "ADA Accessibility Guidelines." While wheelchair access is the focus of much of the standards, keep in mind that the ADA covers barriers to other disabilities too, including hearing, vision, speech and mental disorders.

Other Obligations

Moreover, removing structural barriers is not the only obligation under Title III of the ADA. It also prohibits:

- The use of eligibility criteria that tend to screen out persons with disabilities from enjoying all the services and accommodations you offer. For example, requiring a patient with a disability to be accompanied by an attendant before you treat him or her would not be allowed, even if other patients objected. Certain criteria may be imposed by necessity, such as safety reasons, if based on actual risks and not on stereotypes.

- Failure to modify practices or policies when necessary, unless you can demonstrate that it would fundamentally alter the nature of your practice. For example, if you are a dermatologist you are not required to treat someone who has no skin disorder. However, you may not refuse to treat someone with a skin disorder simply because the person has tested positive for HIV.

- Failure to provide auxiliary aids and services to someone with a disability, unless it would fundamentally alter the nature of your practice or impose an "undue burden" (defined as "significant difficulty or expense.") As an example, the regulations state that a physician advising a deaf patient about surgery or other important matters would be required to provide a sign language interpreter.

When considering what changes you can make at your office, you should take into account the fact that the tax laws have been amended to include deductions and credits in certain cases. Also take into account the cost of non-compliance. Both private citizens and the U.S. Attorney General's Office may bring civil suits to enforce the act. In a suit by a private citizen, the court may grant injunctive relief, including ordering an office to remove barriers and provide auxiliary aids. In a suit by the Attorney General, a court may grant injunctive relief, money damages and civil penalties as high as $100,000 for a second or subsequent violation. Add in your litigation costs, which include attorney fees for a successful plaintiff, and the risk of non-compliance is high.

Doctors who lease office space may be wondering just who must comply, the tenant or the landlord. The ADA offers little guidance. Instead it says the parties are free to allocate responsibility through their lease or a separate agreement. But if anyone is thinking of just letting the landlord worry about it, be aware that the ADA places the burden of complying with Title III on both parties. This could be interpreted to mean they are jointly and severally liable. In other words, even if one party logically bears the burden regarding a certain structural barrier or discriminatory policy, the other could be held liable.

If the ADA seems rather vague, that's because it is. But fortunately, good-faith efforts must be considered by a court in suits by the Attorney General and are likely to be persuasive in private suits as well. In Arkansas, the state Division of Rehabilitation Services and private disability organizations can help you identify the barriers that exist in your office. Deciding exactly which changes are "readily achievable" or the "maximum extent feasible" are legal judgments, ones which the courts will be sorting through in the coming years. Your best defense is a good-faith effort today.

References

1. 42 United States Code Sections 12101 - 12213.
2. 28 Code of Federal Regulations Part 36 (1991). ■

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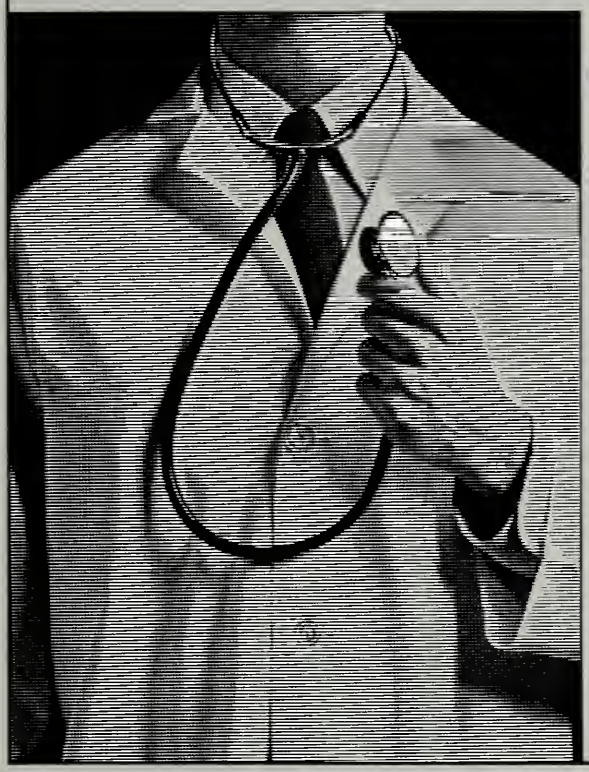

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Breast Cancer: Failure to Diagnose

Judith M. Bulau, M.S.N., R.N.*

Breast cancer is a common disease occurring in one out of 10 women in the United States.[1] Its frequent occurrence places physicians at increasing risk for costly malpractice claims that allege failure to diagnose breast cancer. A recent study conducted by the Physician Insurers Association of America (PIAA), a national coalition of doctor-owned insurance companies, showed that failure to diagnose breast cancer was the second most common reason physicians were sued and the most expensive claim category for medical malpractice insurers.[2]

One of the important findings of the study showed the importance of listening to patients. In 69% of all the claims studied the patient found the lump in her breast but her doctor failed to respond appropriately.[3] The following case provides risk management lessons regarding failure to diagnose breast cancer even when the patient informed her doctor that she found a lump.

Case History

A 28-year-old woman presented to a registered nurse (R.N.) in a gynecological office with a lump in her right breast she noticed about one week before her period, in May 1987. Clinical records indicated that the woman's medical history included several risk factors for breast cancer: three cousins that had mastectomies due to breast cancer; she smoked two to three cigarettes daily and she used oral contraceptives.

A breast examination was performed by the R.N. whose impression was possible fibrocystic breast disease. The R.N. consulted with her supervising gynecologist who ordered a mammogram because of the woman's significant family history of breast cancer. A mammogram was performed seven days later and interpreted as negative.

The woman presented to the same R.N. for vaginal discharge and right breast pain on September 25. Another breast examination was performed by the R.N. who documented, "The right breast in approximately between the 10:00 and 12:00 position there is some fibrocystic changes."

Again, the R.N. consulted with the same physician and it was determined that the breast pain was due to fibrocystic changes. The woman was offered a surgical consultation if she desired but was also informed that her examination was negative. The woman requested a second opinion and was given a referral and appointment to see a surgeon in six weeks.

On October 13, the woman presented to a family practice physician for a second opinion. She complained of a "boil" she noticed a few weeks earlier under her right arm. A breast examination indicated "a 2 cm mass that is mildly tender in the tail of the right breast and she has a 5.5 x 5.5 cm breast mass that is fairly ill-defined involving almost equally in both medial and lateral and superior quadrants of her right breast."

The diagnosis was, "Multiple breast masses probably fibrocystic disease but with markedly positive family history for breast CA certainly needs to be a consideration." A mammogram was scheduled and the woman was advised to keep her appointment with the surgeon.

A mammogram was performed the next day and again read as negative.

The woman made a follow-up visit to the family

* Ms. Bulau is health care manager in the Risk Management Services Division at The St. Paul Companies.

practice physician on October 27. She was no longer having pain in her right axilla or additional problems or complaints. The physical examination was remarkable in that patient "still has a 2 x 2 cm ill-defined nontender soft tissue mass in her right axilla." The diagnosis was, "Right axillary mass." The woman was referred to the surgery clinic for evaluation.

On November 10, approximately six weeks after the woman's September referral to a surgeon, the woman presented to a surgeon. A breast examination was performed and indicated, "right axilla grossly positive; breasts have the nodularity of fibrocystic disease; dominant mass 5 cm in size in the right breast at 12:00 position." Aspiration of the breast mass was obtained and found to be dry. A tru-cut needle biopsy of the mass at 12:00 was performed which indicated "Infiltrating ductal adenocarcinoma, right breast," later classified as Stage III.

The woman was started on three courses of chemotherapy, prior to having a right modified radical mastectomy. Chemotherapy was completed by February 1988.

A right modified radical mastectomy was performed on February 17. The pathology report indicated seven out of 15 nodes were positive.

The woman completed chemotherapy and radiation therapy on October 25. She also had a pregnancy terminated during this time period and in May and December of 1989.

A lawsuit was filed in June 1989 alleging failure to diagnose breast cancer and diminished chance of survival.

Conclusion

At age 31, the woman was diagnosed with metastatic lung cancer, in January 1990. Her prognosis is grim. The defense attorneys gave a 50% chance of winning this case with a possible jury award of $1.5 million to $2.5 million. The case settled out of court for $650,000.

Discussion

During the discovery phase of the lawsuit several significant issues were identified concerning the standard of care for diagnosing breast cancer, staff qualifications, physician supervision of staff and timeliness of patient appointments.

Standard of Care

The issue concerning the standard of care for diagnosing breast cancer focused primarily on questions about the woman's inadequate physical examinations, negative mammograms, lack of follow-up care and delayed surgical consultation.

Inadequate Physical Examinations

One question addressed whether or not the physician and R.N. conducted proper examinations, taking into consideration the physical findings and family history. The woman saw the R.N. for her breast lump because of difficulty scheduling a timely appointment with her doctor. Clinical record documentation indicates that the R.N. "consulted" with her supervising physician after she performed a breast examination, but it is not clear if the physician also conducted a breast examination.

The R.N. and physician said that the use of the word "consulting" always reflected that the patient was examined by the physician. However, the woman reported that the physician did not perform a breast examination, but only looked at her breast. The physician's alleged failure to perform a breast examination was all the more significant in light of the fact the R.N.'s breast examination training had never included palpating a breast cancer mass.

Reliance on Negative Mammograms

Second, a question surfaced about whether or not the physician relied too heavily on the woman's negative mammograms, in spite of the woman's reported breast lump and pain, physical examination findings indicating changes in her breast and positive family history of breast cancer.

Experts for the woman criticized the physician for relying on the negative mammogram results and failing to proceed with a biopsy of the mass. The physician's experts relied on the negative mammogram results, the difficulty of finding a breast cancer mass in fibrocycstic breasts and the inability to perform a biopsy if a mass is not found. However, the woman's experts pointed out that the woman still required close follow-up visits for frequent and repeated examinations even if there were negative mammograms, a mass that could not be palpated, and a biopsy was not performed.

Lack of Follow-Up Care

Whether or not the physician provided adequate and appropriate follow-up care, especially when a biopsy was not done, was another question. There is no documentation in the clinical record reflecting that the mammogram results and a follow-up appointment were given to the woman. During discovery the R.N. said that she received a June 15 telephone message informing her that the woman needed the results of her mammogram and that she had breast pain.

However, the R.N.'s telephone record book did not document any follow-up plan for the woman's breast pain, but only noted that the chart was requested and the mammogram results were negative. The physician denied knowledge of the woman's June complaint of breast pain, saying that she would have referred the

patient to surgery had she been informed. She testified that if the R.N. knew of the woman's complaint of breast pain she did not follow orders to have patients with breast pain seen by the physician. The next documented visit was in September of 1987, three months after the first report of breast pain.

Delayed Surgical Consultation

A fourth question focused on whether or not the woman was promptly referred to a surgeon in light of any suspicion of possible breast cancer, particularly after her September 25 visit. Clinical record documentation indicated that the woman was not seen by a surgeon until six weeks after the September visit. Expert opinion supported having the woman evaluated by a surgeon within one to two weeks of the September visit because the lump continued to exist.

Staff Qualifications

The second significant issue concerned the R.N.'s qualifications. The R.N. was hired to fill a nurse practitioner position, even though she was not certified to practice as one. She was listed as a nurse practitioner under insurance policies. She was also referred to as a nurse practitioner, physician assistant's or obstetrical assistant in various internal documents. The plaintiff maintained that the R.N. was not qualified to be a practitioner, she had not met certification requirements and therefore was practicing beyond the scope of her authority.

However, while the internal paperwork reflected that the R.N. was hired into a nurse practitioner position, the defense position was that the R.N. never represented herself as anything other than an R.N. Her name tag identified her as an R.N., she was trained and experienced in participating in medical care, she did not diagnose patients but simply made physical assessments and she was under the supervision of a physician.

Physician Supervision of Staff

Another important issue centered around the physician's supervision of the R.N. The staff and R.N. functioned on an informal basis without the aid of any written policies and procedures that would inform staff when patients were required to be seen by the physician, rather than the R.N. No guidelines determined when the R.N. was required to consult her supervising physician or how the R.N. was to perform the medical aspects of patient care that were delegated by the physician. There was evidence that the lack of written patient care protocols to assist the staff in providing care and the physician in supervising such care, prevented the woman from receiving quality health care.

Timeliness of Patient Appointments

A fourth major issue addressed the ability of the woman to obtain timely appointments with her physician. The woman said she attempted to schedule an appointment with her physician but instead she was forced to see the R.N. because she could not obtain a timely appointment with her physician. In addition, as discussed previously, the woman's appointment with a surgeon was delayed by six weeks because she was not given a prompt referral.

Evidence showed that the inability of the woman to obtain timely appointments and referrals prohibited her prompt access to appropriate medical care.

Claim Data

The 273 breast cancer claims that PIAA studied resulted in total paid claims of $60.5 million, with the average payment being $221,524.[8] The study found that women under 50 years of age filed 69% of the claims with these claims representing 84% of the total payments.[9] Forty percent of the claims were filed by women under 40 years of age and accounted for 58% of the $60.5 million paid.[10] Numerous causes accounted for failure to diagnose breast cancer, with the top three being: 1) physical finding failed to impress - 54.7%; 2) negative mammogram report - 35.7%; and 3) failure to do appropriate biopsy - 26.8%.[11]

References

1. American Cancer Society, Cancer Facts & Figures, 1990, p.10.
2. Physician Insurers Association of America, Breast Cancer Study, 1990, p.3.
3. Ibid.
4. American Cancer Society, Cancer Facts & Figures, 1990, p.10.
5. Malcom JP, Physicians & Surgeons Update, 1991, p.11.
6. Ibid.
7. Chizek M, QRC Advisor, February 1990, p.8.
8. Physician Insurers Association of America, Breast Cancer Study, p.9.
9. Physician Insurers Association of America, Breast Cancer Study, p.15.
10. Physician Insurers Association of America, Breast Cancer Study, p.7.
11. Physician Insurers Association of America, Breast Cancer Study, p.13. ■

Risk Management Tips

The following risk management guidelines may be useful in ensuring quality and safe health care for breast cancer patients. Many of these guidelines apply to the risk management concerns raised in the case history.

Hire personnel into appropriate positions, taking into consideration the scope of the practice for which they are oriented, educated and qualified to provide care.

Use qualified practitioners appropriately, according to their job assignment and scope of practice.

Establish written guidelines for breast cancer diagnosis, treatment and management, including:

- ✔ A comprehensive history and physical examination of all body systems, bilateral breast examinations, documenting the left and/or right breast, site and size of breast mass, and second physician opinion as necessary.
- ✔ Recommendations for mammography screening. A baseline mammogram at age 35 to 39, a mammogram every one to two years between age 40 and 49 and every year at age 50 and above is recommended.[4] An annual mammogram is recommended for anyone with previous breast cancer or who is considered at high risk based on family history, and for every patient over age 30 with a breast complaint.[5]
- ✔ Recommendations for performing biopsy. A biopsy is usually indicated for a solid breast mass and a suspicious mammogram. For a negative mammogram with a definite breast mass, the physician should ignore the negative mammogram and proceed with a biopsy of the mass. If a solid mass is present and a negative needle biopsy is obtained, then the negative needle biopsy should be ignored and an additional biopsy pursued. Adequate follow-up must be implemented on all patients not having a biopsy.[6]
- ✔ Recommendations for retaining biopsy specimen for the defense of future claims whenever there may have been a failure or delay in diagnosing breast cancer.
- ✔ Recommendations for management of breast cancer.
- ✔ Prompt referral to consulting physician.
- ✔ Communication between the attending physician and radiologist, and attending physician, consulting physician and patient.

Establish written policies and procedures for:

- ✔ Scheduling timely appointments and follow-up visits.
- ✔ A call-back system that will notify each patient who has received diagnostic tests, of abnormal diagnostic test results that were not available during the physician visit.
- ✔ Legible, accurate and complete documentation of all patient care, communications and recommendations, including informed consent; mammography, such as naming the facility where the examination is to be done, indications for the examination, expectations for immediacy of the examination, communication to the patient regarding the examination results and/or follow-up appointment;[7] follow-up visits; patient cancellation or failure to keep follow-up appointments; attempts made to contact patient for rescheduling follow-up appointment; referral to, and subsequent scheduling for visit with consulting physician.

Establish a system for monitoring and assessing quality of care relative to breast cancer diagnosis issues and patient and personnel satisfaction, including evaluation of:

- ✔ Physician involvement in the care of all patients seen in the gynecological office.
- ✔ Practitioner hiring practices.
- ✔ Use and supervision of practitioners.
- ✔ Diagnosis, treatment, and management of breast cancer patients.
- ✔ Communication between attending physician, consulting physician, and patient.
- ✔ Patient access to health care.
- ✔ Call-back system for communicating abnormal radiology and laboratory results to patients.
- ✔ Ability of patients to obtain timely appointments and prompt follow-up care.
- ✔ Ability of patients to have access to a physician.
- ✔ Contact with patients who cancel or fail to keep follow-up appointments.
- ✔ Documentation of patient care, communications and recommendations.
- ✔ Involve management, physicians and staff in quality and risk management activities.
- ✔ Provide educational opportunities for physicians and staff to develop and maintain their expertise and skills.

Arkansas HIV/AIDS Report 1983-1992

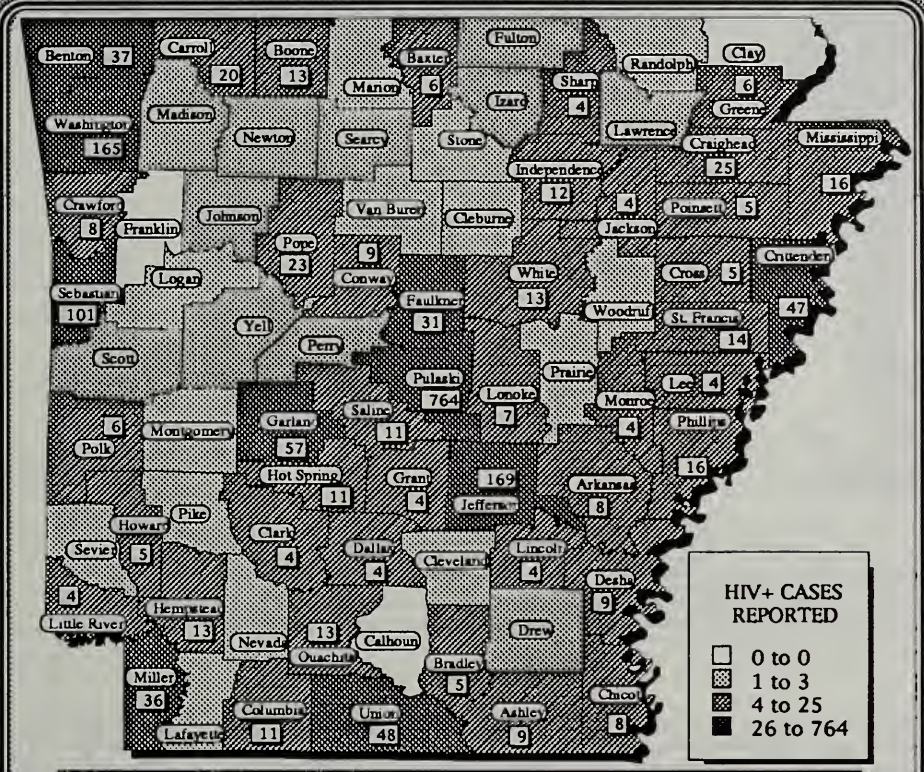
Arkansas: June 1983 through May 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	438	420	155	1,580	85.54
	Female	1	1	6	27	39	71	90	32	267	14.46
AGE	< 5	0	0	1	1	2	9	14	3	30	1.62
	5-12	0	0	0	1	1	5	2	0	9	0.49
	13-19	0	0	0	8	8	14	20	12	62	3.36
	20-29	8	10	15	109	124	192	152	81	691	37.41
	30-39	7	15	22	86	105	206	217	69	727	39.36
	40-49	4	7	11	24	35	61	72	16	230	12.45
	> 49	1	1	6	6	12	19	23	6	74	4.01
	Unknown	0	0	0	8	3	3	10	0	24	1.30
RACE	White	16	24	47	171	178	353	310	110	1,209	65.46
	Black	4	9	8	70	107	152	195	74	619	33.51
	Other	0	0	0	2	5	4	5	3	19	1.03
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	187	1,847	100%

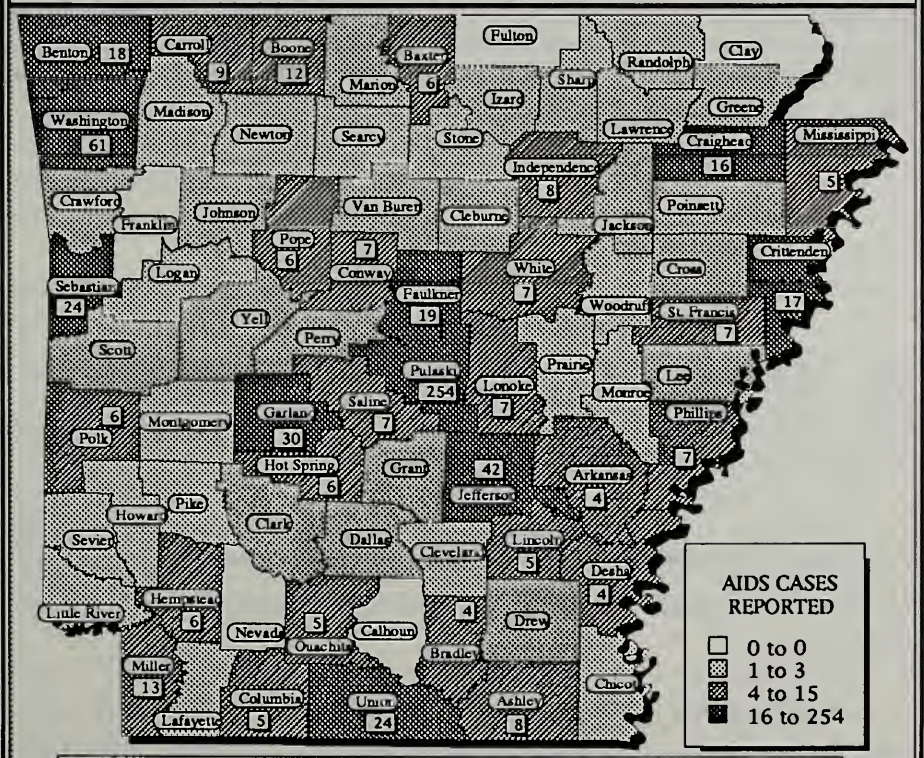
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	75	653	89.45
	Female	1	0	4	6	10	20	25	11	77	10.55
AGE	< 5	0	0	0	1	1	6	6	0	14	1.92
	5-12	0	0	0	1	0	1	1	0	3	0.41
	13-19	0	0	0	0	0	4	3	1	8	1.10
	20-29	7	9	15	27	24	55	57	27	221	30.27
	30-39	3	13	23	36	41	78	80	36	310	42.47
	40-49	1	6	8	10	7	35	41	16	124	16.99
	> 49	1	0	4	8	7	11	13	6	50	6.85
RACE	White	9	22	43	61	58	141	134	59	527	72.19
	Black	3	6	7	20	21	47	66	26	196	26.85
	Other	0	0	0	2	1	2	1	1	7	0.96
RISK	Male/Male Sex	7	17	31	59	50	118	118	50	450	61.64
	Injection Drug User (IDU)	0	2	10	4	11	18	28	13	86	11.78
	Male/Male Sex & IDU	3	9	4	6	6	18	17	6	69	9.45
	Heterosexual	2	0	2	3	6	10	10	8	41	5.62
	Transfusion	0	0	2	7	3	7	11	1	31	4.25
	Perinatal	0	0	0	1	1	6	6	0	14	1.92
	Hemophiliac	0	0	0	1	1	5	5	2	14	1.92
	Undetermined	0	0	1	2	2	8	6	6	25	3.42
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	86	730	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 1,847 Arkansans have been reported to be HIV+ as of May 25, 1992.



A total of 730 Arkansans have been diagnosed with AIDS as of May 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

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Russellville

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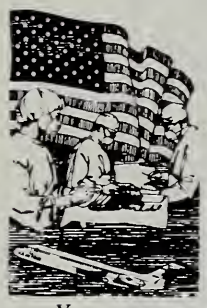

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WORKMAN'S COMP
ICD DIAGNOSIS CODES
REFERRING PHYSICIAN SECONDARY
GROUP NUMBER HICFA
PLACE OF SERVICE CODE
PRIMARY CARRIER
PRIOR AUTHORIZATION
TYPE OF SERVICE CODES
SAME/SIMILIAR INDICATOR
PATIENT CHARTS DAY SHEETS
SUPERBILL
CPT PROCEDURE CODES
WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN
ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE
DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT
APPROVED AMOUNT TYPEWRITER
CODING REQUIREMENTS
APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES DATE OF DISABILITY
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Radiological Case of the Month

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Figure 1

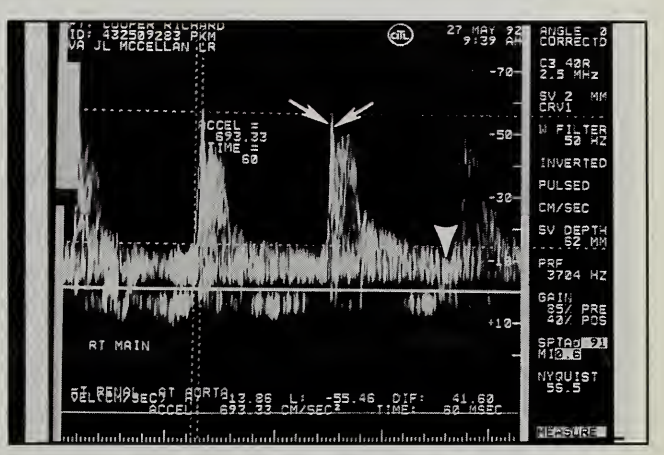

Figure 2

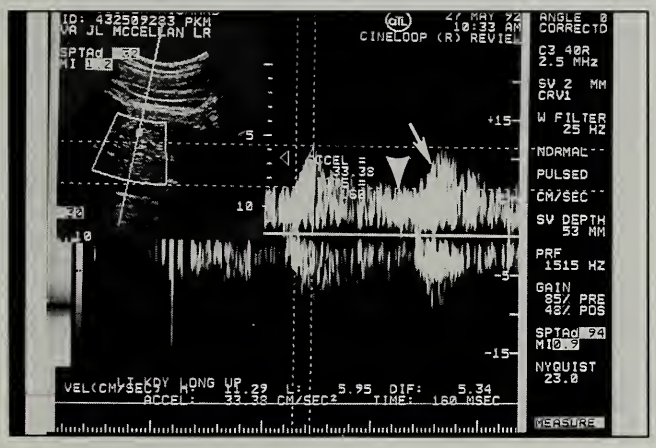

Figure 3

History:

The patient was a 65 year-old gentleman who presented with hypertension which had worsened acutely and was not controllable on standard medical management. The patient's physical examination was significant for a bruit over the left mid abdomen. The patient had blood pressure changes which had resulted in elevation to 210/130 mm Hg. with serum creatinine level of 3.2.

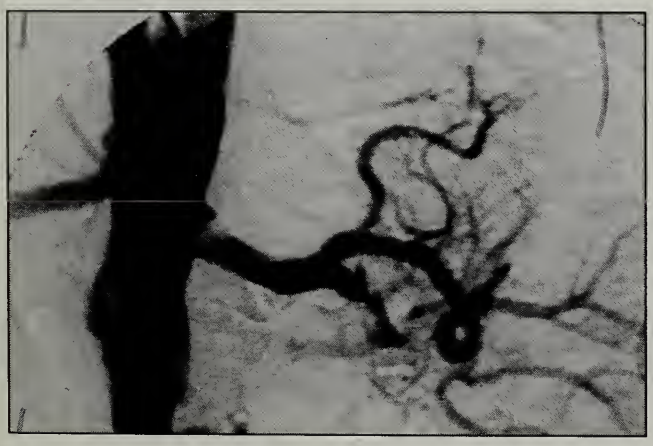

Figure 4

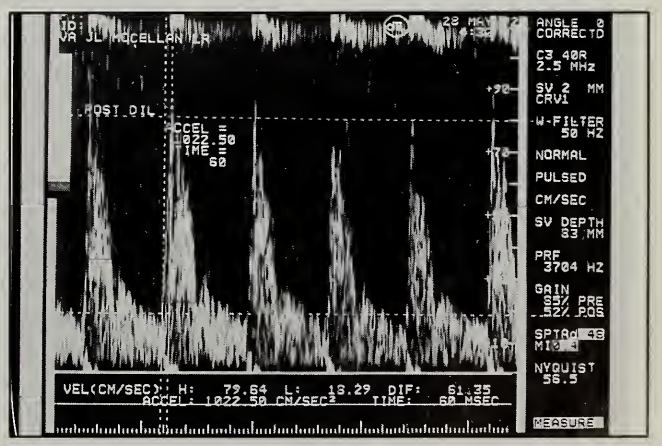

Figure 5

Tardus Parvus Abnormality in Renal Artery Stenosis

Findings:

Figure 1 is the abdominal aortogram in this patient. This was performed after duplex evaluation of the kidneys revealed abnormal waveforms in the left renal hilus consistent with renal artery stenosis. The pre-arteriographic duplex waveforms are shown as figure 2 from the right kidney and figure 3 from the left kidney. These waveforms were not obtained directly from the aorta or along the course of the main artery but as indirect measurements of the renal artery obtained from the hilar vessels in the renal bed proper. Indirect (downstream) waveforms can be obtained in almost 100% of patients. The slow blood flow seen downstream from a stenosed renal artery can be detected by analyzing these waveforms much the same as EKG measurements reveal abnormal conductance of electrical flow in the heart. The normal waveform obtained from the right kidney (fig. 3) correlates with the normal arteriographic appearance of the right renal artery (fig. 1). This waveform shows a sharp early systolic peak (arrows) and an acceleration time of 60 milliseconds (normal range is <7msec). Contrast this to the waveform obtained from the left kidney (fig. 3). Downstream from the abruptly narrowed renal artery stenosis, the waveform is diminished in height and the slope of the systolic upstroke is flattened (fig. 3 arrow) with a measured acceleration time prolonged to 160 milliseconds because of the proximal obstruction. Also note the increased diastolic flow (fig. 3 arrowhead) which is seen in patients secondary to vasodilatation of the arteriolar bed downstream from significant arterial stenosis. The patient had balloon dilatation performed with a 6mm outer diameter balloon which revealed a less than "perfect" angiographic result (fig. 4). However, by performing a simultaneous Doppler of the left kidney, it could be seen that the waveform (fig. 5) had returned to normal (acceleration time of 60 milliseconds) and was similar to the pattern seen in the normal right renal artery. Thus, post-angioplasty, although the arteriographic result did not appear perfect, by demonstrating normal waveforms we can be confident that there is no hemodynamic significance to any narrowing that may persist angiographically. This will help eliminate the risk of over dilatation or unnecessary redilatation based on arteriographic results.

Discussion:

Renal artery stenosis (RAS) by activating the renin-angiotensin mechanism may lead to renovascular hypertension (RVH). RAS and RVH are not synonymous. Mere presence of RAS does not prove that it is the cause of hypertension. Hypertension may antedate RAS. RAS may develop as a consequence of hypertension induced accelerated atherosclerosis. For this reason, the presence of RVH can only be proved retrospectively. The hypertension must resolve or dramatically improve after successful repair of RAS to prove the existence of RVH. To date there has been no noninvasive diagnostic test which can both detect RAS and predict whether or not it is causing RVH. Many diagnostic laboratory imaging tests have been devised to detect RAS. These include excretory urography, radionuclide renography, captopril renography, renal arteriography, renal vein renins, duplex sonography, and color duplex sonography. Renal arteriography is considered the goal standard but is expensive and invasive and is unsuitable as a screening test. By detecting and repairing the underlying RAS, RVH may be controlled and its complications minimized.

Previous low success rates preforming direct Doppler evaluation of the main renal artery to detect stenosis have been related to inadequate sensitivity and specificity. The direct signs of RAS are similar to direct signs of hemo-dynamically significant stenosis in other arterial systems. Increased velocities through the stenosis and turbulence distal to the lesion are direct signs of RAS. The models for detecting and grading stenosis in the carotid and femoral arterial systems are generally applicable to the renal arteries, but with far greater technical difficulties and limitations encountered in renal exams. Indirect Doppler findings of RAS are detectable in vessels remotely distal to the site of actual stenosis. This includes the distal main renal artery

and the segmental and interlobar branches of the renal arterial system. Kotval described findings in the vertebral artery waveforms distal to subclavian stenosis which he termed Parvus and Tardus. These terms were originally used to describe the dampened and delayed palpable pulses distal to aortic valvular stenosis. Because the segmental artery waveforms distal to RAS are also dampened and have a delay in early systole, we have similarly used the term Tardus-Parvus to describe them.

We are currently doing research to evaluate our ability of utilizing this method to prospectively distinguish between incidental RAS and stenosis which is actually causing RVH. Early results are very encouraging. These changes are not related to the Tardus-Parvus abnormalities. They are related to the difference in resistive indices between kidneys ipsilateral and contralateral to the RAS. We are noting that the resistive index distal to renal artery stenosis is not only much lower (more receptive to inflow) than the resistive index in the contralateral kidney, but much lower than normal. In the example used in this case, the increased diastolic flow (low resistance bed) downstream from the stenosis can easily be seen in comparison to the relatively lower diastolic flow (higher resistance bed) in the right kidney. Prior to dilatation, the resistive index in the left kidney was .47 and the resistive index in the right kidney was .75 (normal for patient ages <.7). The resistive index distal to renal artery stenosis is frequently below .5 and maybe as much as 20% or more lower than in the contralateral "normal" kidney. We believe this is a manifestation of the renin-angiotensin mechanism, which causes the afferent arterioles to dilate and the efferent arterioles to constrict in order to improve the glomerular filtration. This suggests that afferent arterioles are more important in determining the resistive index than the efferent arterioles. More importantly it implies that the small muscular arteries within the kidney are still reactive and able to dilate and constrict normally. It implies that there is no fixed small vessel disease which antedated the development of RAS and which could prevent beneficial blood pressure response to the repair of RAS. We have preliminary evidence that diastolic blood pressure falls more (higher success rates) in patients who have lower pre-dilatation resistive indices distal to the RAS than on the contralateral side (as was the case in this patient).

When first learning to use this pattern recognition approach to indirect waveform analysis, one should do it in conjunction with standard direct interrogation of the main renal arteries, if possible. Additionally, angiographic correlation is imperative. One approach to gaining the experience is to offer to perform free limited segmental arterial interrogation immediately prior to angiography (or after, if angiogram results are unknown) in a number of patients undergoing aortography and run-offs as well as all patients undergoing renal arteriography. Additionally, patients with peripheral vascular disease have about a 10% change of having renal artery stenosis, rather than the 1-2% incidence in the general population of hypertensives.

References

1. Handa N, et al. Efficacy of echo-Doppler examination for the evaluation of renovascular hypertension. Ultrasound in Med & Biol, 1988; 14:1-5.

2. Handa N, et al. A new accurate and non-invasive screening method for renovascular hypertension: the renal artery Doppler technique. J Hypertension, 1988; 6 (suppl):s458-s460.

3. Martin RL, et al. Renal hilar Doppler analysis in the detection of renal artery stenosis. J Vascular Technology, 1991; 2=15 (4):173-180.

4. Kotval PS. Doppler waveform parvus and tardus: a sign of proximal flow obstruction. J Ultrasound Med, 1989; 8:435-440.

5. Stavros AT, et al. Segmental renal artery tardus-parvus waveform abnormalities - pattern recognition approach to duplex sonographic diagnosis of renal artery stenosis, 1992; Radiology (to be published).

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.

Contributor: Thomas A. Stavros is director of ultrasound at the Swedish Medical Center in Englewood, Colorado.

Medicine in the News

Health Care Access Foundation Update

As of May 1992, the Arkansas Health Care Access Foundation has provided free medical services to 4,105 medically indigent persons.

The program has 1,505 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Of Human Interest

On November 11, 1991, while cooking lunch in a deer hunting camp near Sitka (Sharp County), Robert Quevillon, M.D., an Internist from Walnut Ridge, started an experience to remember. A member of his party suffered a cardiac arrest.

Bob started cardio pulmonary resuscitation with the help of a bystander, Donald McFall Jr., of Black Rock and recent graduate of Arkansas State University, with no previous CPR experience exposure. This effort continued for an hour until the ambulance arrived on the scene. The ambulance's lights knocked off the roof as it came into the camp. The shocking device brought in by the ambulance failed to restore normal heart rhythm. CPR was continued on the way to Baptist Memorial Hospital in Cherokee Village. Here, ventricular fibrillation was corrected. The patient became conscious and was transported to St. Bernards Regional Medical Center in Jonesboro, where cardiologists Michael Camp, M.D. and Mark Levinson, M.D. assumed his care.

The patient was alert and responsive but it was difficult to maintain an effective rhythm and blood pressure. Emergency coronary catheterization showed no significant artery disease, but a diffuse cardiomyopathy. Supportive measures were unsuccessful and he expired near noon the following day.

It is remarkable that CPR was maintained this effectively for exactly two hours, under field conditions, by a physician and an assistant with no previous experience. Without the underlying cardiomyopathy, Bob and Don just might have pulled it off.

The previous story was submitted by G. Durwood Wisdom, M.D., physician representative, St. Bernards Regional Medical Center in Jonesboro.

In Memoriam

Harmon Lushbaugh, M.D.

Dr. Harmon Lushbaugh, a retired obstetrician and gynecologist from Lowell, died Sunday, May 17, 1992. He was 59.

Dr. Lushbaugh was a member of the Arkansas Medical Society and the Washington County Medical Society.

Survivors are his wife, Susan of Lowell; three children; and a brother.

Bert L. Phillips, M.D.

Dr. Bert L. Phillips, an ophthalmologist from North Little Rock, died Tuesday, May 12, 1992. He was 87.

Dr. Phillips was a life member of the Arkansas Medical Society and a member of the American Medical Association and the Pulaski County Medical Society.

Dr. Young is survived by a son, Kim Phillips of Dallas, TX; and three grandchildren.

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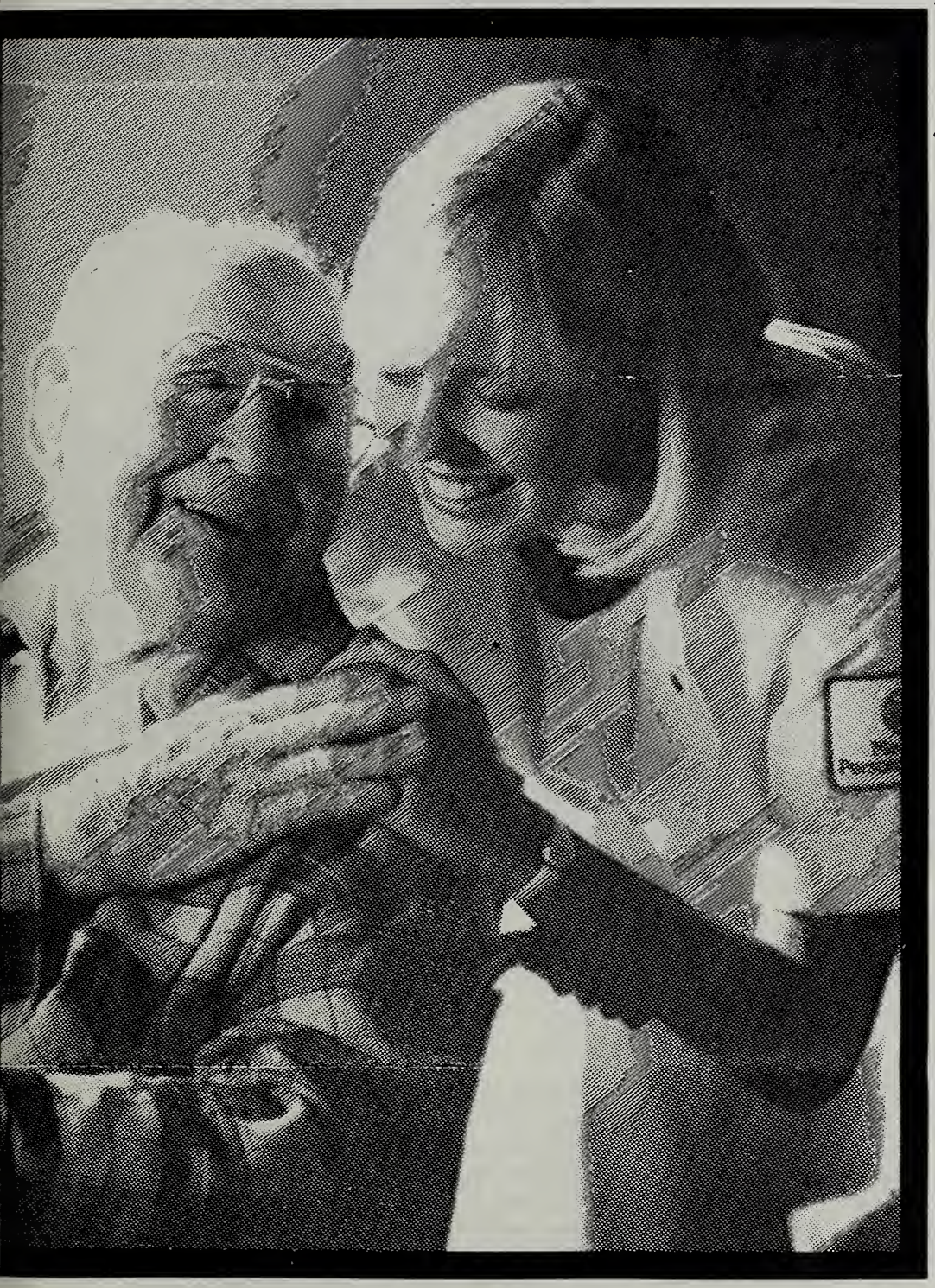

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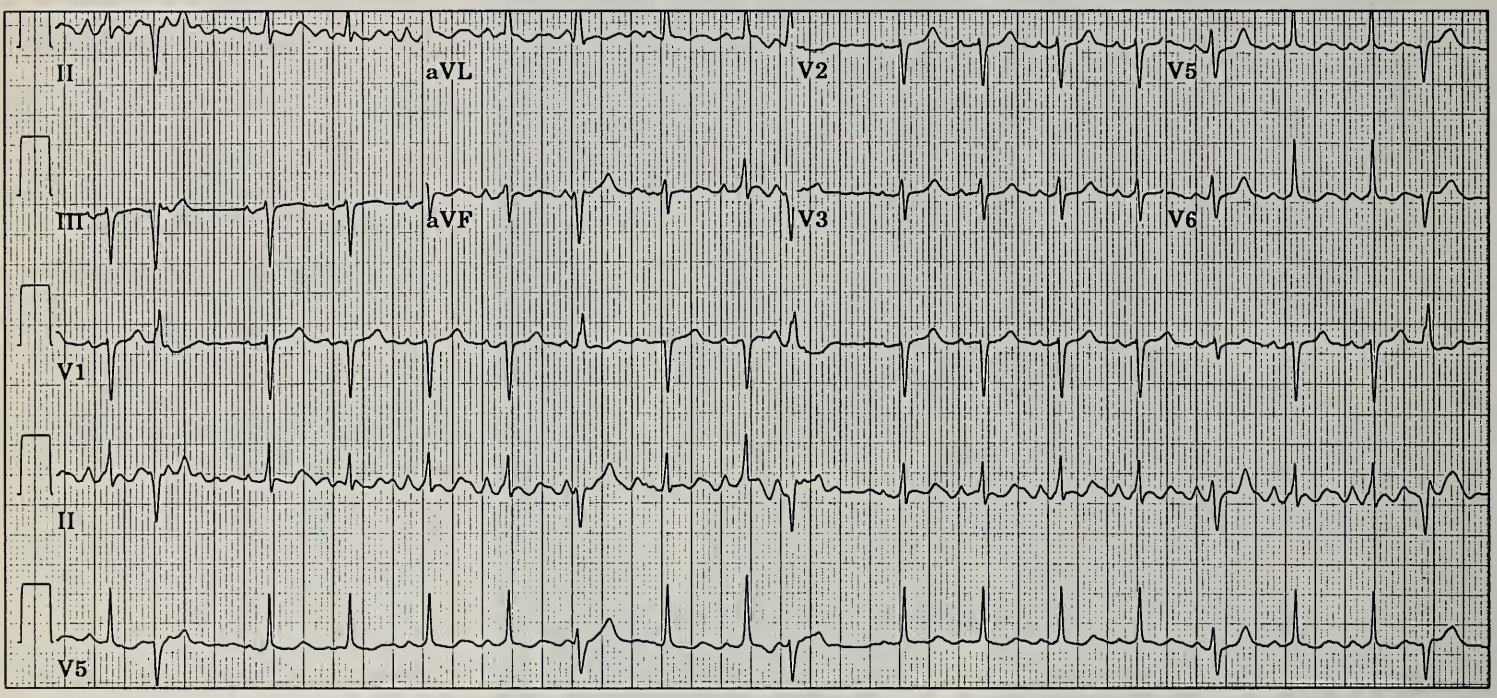
Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

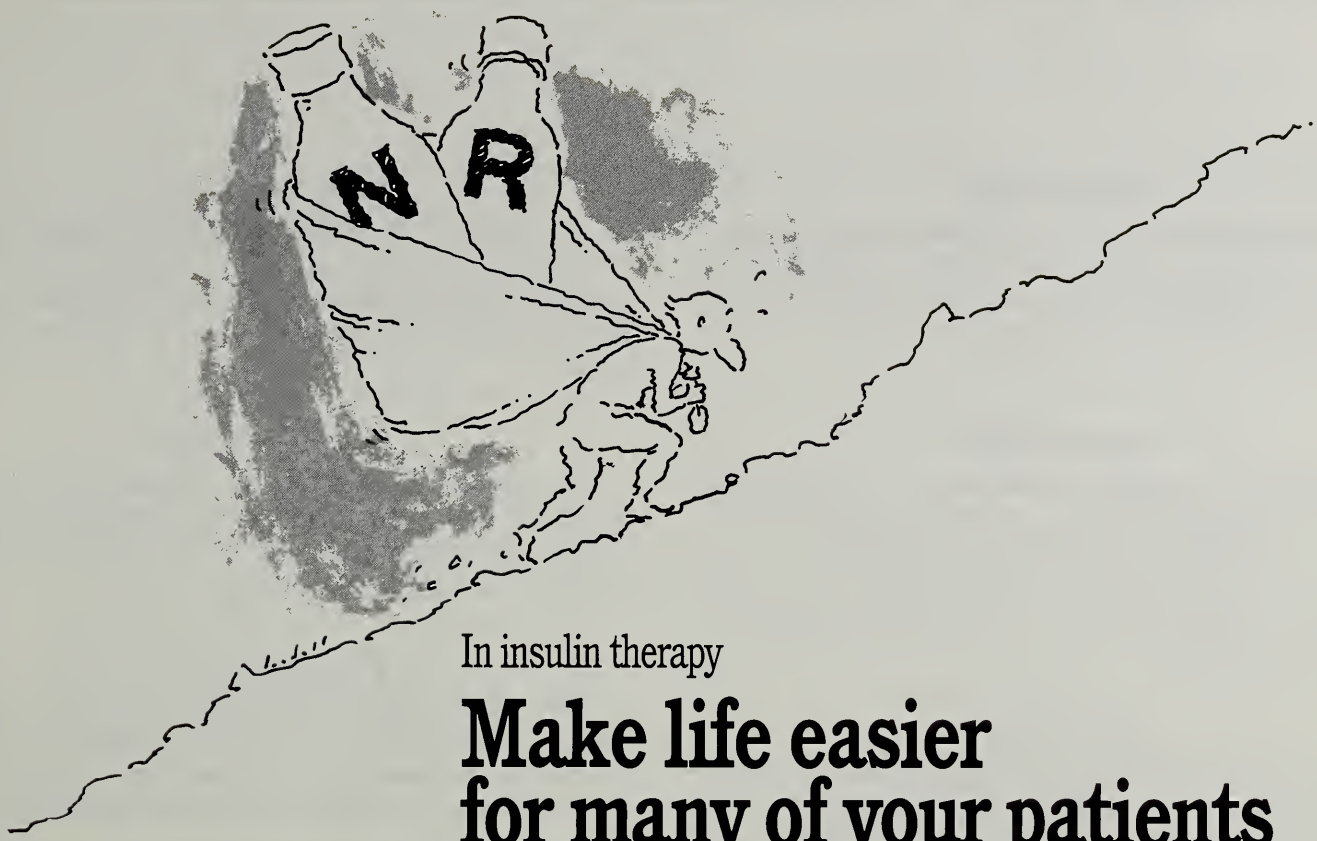
HISTORY:

This record was obtained from a 77-year-old female who was recovering from general anesthesia.



DISCUSSION:

Not all ECG recordings are of textbook quality. However, many such recordings must be interpreted because of the information they provide about the patient. This is one such recording. The underlying atrial mechanism is sinus tachycardia at a rate of 110 per minute. The conducted QRS complexes are of normal contour and duration, indicating normal intraventricular conduction. Interspersed among the conducted complexes at regular intervals are QRS complexes with varying morphology and widened QRS duration. These are PVC's. The coupling intervals between the PVC and the preceding QRS complex also vary; this is termed *variable coupling.* Focussing on the V5 rhythm strip, it is evident that the first and last PVC have a QS morphology. The second and fourth PVCs are preceded by P waves and have a QRS morphology intermediate between that of the normally conducted complexes and the first and last PVCs. These complexes represent *fusion complexes* and result from depolarization of the ventricles by both the ventricular ectopic focus and by the sinus impulse via the His-Purkinje system. The intervals between the first and second PVC and the third and fourth PVC are exactly twice the interval between the second and third PVC, indicating a *common interectopic interval.* If the interval between the second and third PVC is taken as the rate of depolarization of the ventricular focus, it is evident that in the long intervals between the PVCs, the ventricular focus would be expected to depolarize shortly after the conducted QRS complex, i.e. during the absolute refractory period of the ventricles. Thus one would not expect the PVC to depolarize the ventricle. Finally, depolarization of the ventricles by the sinus mechanism does not interfere with the ventricular focus, a manifestation of *entrance block.* This record satisfies all of the requirements for the diagnosis of ventricular parasystole. The features include: 1) variable coupling; 2) a common interectopic interval; 3) fusion complexes; 4) entrance block or "protection;" and, 5) failure of the ectopic focus to manifest because of the physiologic refractoriness of the surrounding myocardium.



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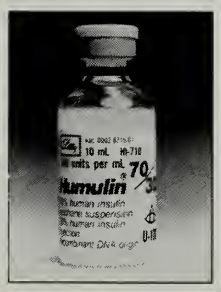

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Things To Come

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Personality and Political Behavior. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

July 26-30

Current Concepts in Cardiology. Hyatt Regency Lake Tahoe, Incline Village, NV. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: to be announced. Category I credits available. For more information, call (916) 734-5390.

July 27-31

Learning Disorders in Childhood and Adolescence. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 3-7

Diagnosis and Treatment of Sexual Problems. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 3-7

Child Assessment and Psychotherapy. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 5-7

9th Annual Meeting of the SOA. Chateau Whistler Resort, Whistler, British Columbia. Sponsored by the Southern Orthopaedic Association. For more information, call (205) 945-1848 or 1-800-423-4992.

August 6-8

Clinical Allergy for the Practicing Physician. The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

August 10-14

Psychotherapeutic Intervention Following Head Injury. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 10-14

Treatment of Battering and Incest. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 13-15

5th Annual Meeting of the SAO. Westin Resort, Hilton Head Island, South Carolina. Sponsored by the Southern Association for Oncology. For more information, call (205) 942-0530 or 1-800-423-4992.

August 23-28

New Advances in Internal Medicine: Clinical Applications. Hyatt Regency, Monterey, CA. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: $480 physicians; $350 others; military discounts available. Category I and AAFP credits available. For more information, call (916) 734-5390.

August 24-28

Neuropsychological Assessment: New Directions. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

Psychoanalytic Theory and the Clinical Interchange. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

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Keeping Up

University/Based Perinatal Continuing Education Seminar

August 7, 7:30 a.m., UAMS Education II Building. Sponsored by the UAMS College of Medicine. Presented by J. Gerald Quirk, M.D. CME Category I credit available. Fees: $25.00. For more information, call Cindy Reid at 686-5261.

Arkansas Academy of Family Physicians' 45th Annual Scientific Assembly

July 30-August 2, Excelsior Hotel/Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. Twenty-one AAFP prescribed hours available. For program or registration information, call the AAFP at 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC
Medical Grand Rounds, Thursday, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 11:30 a.m., conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided. Category 1 credits available.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room

Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

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Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

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AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom

Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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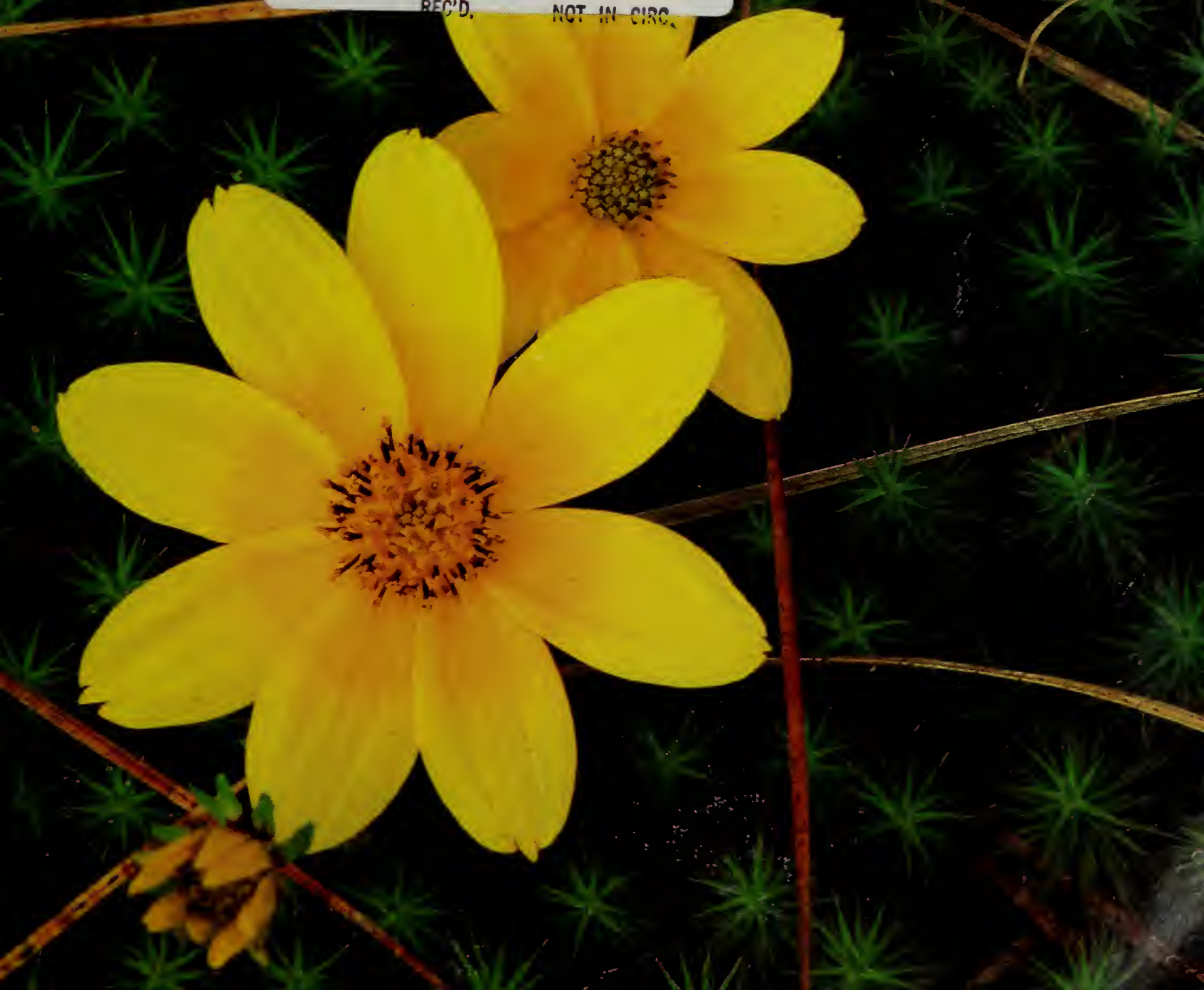

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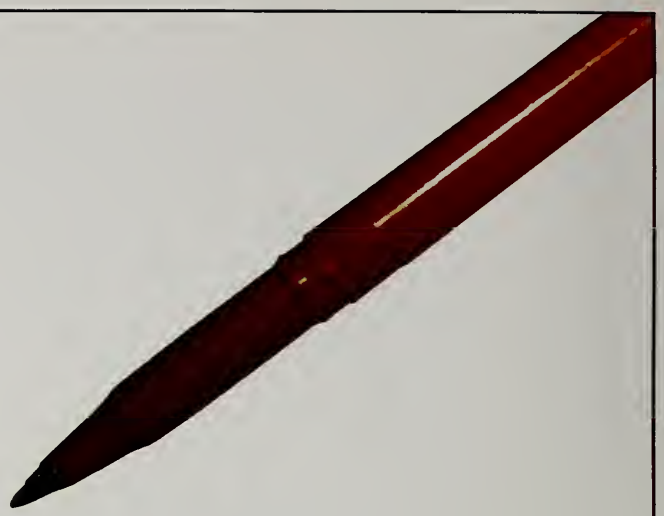

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Cover photo was taken by AMS member M.C. Milligan, M.D., a retired physician from Pine Bluff.

An Early Case of the Zollinger-Ellison Syndrome Produced by a Carcinoid Tumor of the Duodenum

John D. Olson, M.D.

In 1955, Zollinger and Ellison[1] first reported on an ulcerogenic islet cell tumor of the pancreas which was responsible for severe gastric hyperacidity leading to a severe ulcer diathesis. This discovery opened the way for modern gastrointestinal endocrinology. Later on, it was discovered that carcinoid tumors in the duodenum or stomach could also produce this same problem.

The case which we are presenting had surgery in January 1957, a relatively short time after the original report by Zollinger and Ellison, and apparently our finding of a carcinoid tumor occurred before it was fully recognized that a carcinoid could also produce gastrin.

Carcinoid tumors of the GI tract are relatively rare, and are most uncommonly found in the duodenum, where only about 1% are found. It has been estimated that only about 10% of carcinoid tumors of the duodenum produce the Zollinger-Ellison Syndrome.[2]

Shortly after we discovered this case, I talked personally with Dr. Ellison at a surgical meeting, and he expressed a "desire to see the slides," and apparently was probably unfamiliar with the pathophysiology.

We must remember that at the time that this case was done, studies of gastrin were not universally available, and H2 antagonists were not on the market.

This case has been sitting on my shelves gathering dust for many years, and somehow it occurred to me that it might be worthy of publication.

Case Report

In late 1951, the patient, "W.L.," came under my care. He was 66 years of age at this time and gave a history that he had had closure of perforated duodenal ulcer in 1932 at the age of 46.

Shortly thereafter, in 1933, he underwent a posterior gastroenterostomy for ulcer complications, probably obstruction. Both of the procedures were done "elsewhere."

When I first saw this individual, he was complaining of severe ulcer-like pain, and x-rays disclosed the presence of a malfunctioning gastrojejunostomy with an anastomotic ulcer. At this time, he was also complaining of diarrhea, and had been for a number of years.

He was taken to surgery on January 2, 1952 and found to have a tremendous marginal ulcer at the site of the anastomosis.

Take-down of the gastroenterostomy was accomplished, along with a resection of the stomach and a Billroth #2 reconstruction was performed.

He then did fairly well for a relatively short period of time, and it was felt that some of his GI problems were due to domestic difficulties.

He continued to have some diarrhea and also then developed ulcer-type pain again. X-rays again disclosed the presence of a marginal ulcer at the anastomosis.

Surgery was advised, and on October 2, 1954, he

was taken to surgery and found to have a huge marginal ulcer at the anastomosis. Re-resection of the stomach and a truncal vagotomy was carried out. Following this, he did well for a brief period of time, but in February 1955 he had recurrence of ulcer symptoms and continued diarrhea. X-rays again disclosed the presence of a recurrent marginal ulcer.

Surgery was again carried out on January 11, 1957, and on this date we were aware of the Zollinger-Ellison Syndrome reported in 1955. At this surgery, the recurrent marginal ulcer was huge, and was attached to the anterior abdominal wall.

At this time, the anastomosis was taken down, the jejunum was resected, and an end-to-end jejuno-jejunostomy was performed. Re-resection of the stomach was done with reconstruction by a Billroth #2 procedure.

At this time, careful search for a pancreatic tumor was made, but none was found.

As a "last resort" to try to solve this dilemma, I freed up the duodenal stump in the hope that we might be dealing with retained gastric antrum. A small, flat, round tumor was found in the first portion of the duodenum anteriorly. This was removed. The redundant portion of the duodenal stump was then removed, searching for gastric tissue, but none was found. This duodenum was closed, and the patient made an uneventful recovery.

Pathologically, the tumor was diagnosed as being a carcinoid of the duodenum with blood vessel invasion.

Following this surgery, the patient did exceedingly well except for the continued intermittent diarrhea which was fairly well controlled by the use of Lomotil.

This patient expired on May 29, 1979, at the age of 93, 22 years after his last surgery. It was thought that the continuation of his diarrhea might possibly be due to metastasis from the carcinoid tumor but this was never proven.

Summary

We have reported a case of Zollinger-Ellison Syndrome which proved to be due to a small carcinoid tumor of the wall of the duodenum.

At the time that this was found, I could not find any such cases in the literature. In talking with Dr. Ellison personally, it was my impression that he was probably not aware of this syndrome. There are relatively few cases in the literature, and in a report by Dr. Van Heerden, et al[2] from the Mayo Clinic, of 154 patients with carcinoid tumors of the GI tract, there were only two cases of the carcinoid tumor found the duodenum. One had a gastrin producing tumor 1 cm in diameter with positive nodes which was excised locally, and the patient was alive and well and not taking medication after 10 years.

In this case, I think that serendipity played a great part, because I had no knowledge of the relation between the carcinoid tumor and the severe ulcer diathesis it produced.

References

1. Zollinger RM, Ellison RH. Primary peptic ulcerations of the jejunum associated with islet cell tumor of the pancreas. Annals of Surgery, 1955, 142-709.

2. Thompson, et al. Carcinoid tumors of the gastrointestinal tract: presentation, management and prognosis. Surgery, December 1985, pp. 1054. ■

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St. Louis Encephalitis in Arkansas

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N. Karabatsos, PhD,[2] P. Moore, MD, MPH,[2]
T. Tsai, MD, MPH,[2] A.C. Olin,[3] J.P. Lofgren, MD, DTM&H,[4]
Brent Higdem, MBA,[5] T.E. Townsend, MD[5]

The first outbreak of St. Louis encephalitis (SLE) in Arkansas occurred in Pine Bluff (Jefferson County) during July-August 1991. Cases of SLE were identified mainly through reporting by physicians in Jefferson and surrounding counties. In addition, testing of stored cerebrospinal fluid specimens, a hospital chart review, and a serosurvey were performed in Pine Bluff. Twenty-eight Arkansas residents, five of whom died, had cases of SLE. Half the case patients were over age 60, and nearly half had hypertension. The serosurvey confirmed that infection with the SLE virus was not new to Pine Bluff, and that most infections in 1991 were asymptomatic. Arkansas physicians may see more cases of SLE in 1992. SLE epidemiology, clinical presentation, diagnosis, and preventive measures are reviewed.

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2. Dr. Marfin and Dr. Karabatsos are with the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases at the Centers for Disease Control, Fort Collins, Colorado.
3. Mr. Olin is with the University of Illinois School of Public Health, Chicago, Illinois and the Association of Schools of Public Health, Washington, D.C.
4. Dr. Lofgren is with the Bureau of Health Resources at the Arkansas Department of Health, Little Rock, Arkansas.
5. Mr. Higdem and Dr. Townsend are with the Jefferson Regional Medical Center, Pine Bluff, Arkansas.

During July and August 1991, the mosquito-borne St. Louis encephalitis virus (SLEV) caused 28 cases of St. Louis encephalitis (SLE) in Arkansas. These cases represented one of two 1991 outbreaks in the United States, and the first ever in Arkansas. A preliminary report on the Arkansas outbreak—focused in Pine Bluff, Jefferson County—was published elsewhere last year.[1] This is a more complete report on the outbreak, with recommendations for Arkansas physicians in 1992.

Facts about SLEV, the leading cause of arboviral encephalitis in the U.S., are summarized in Table 1. More detailed information can be found in several sources.[2-6]

Background

The first three cases of SLE among Arkansas residents in 1991 were diagnosed by neurologists at Jefferson Regional Medical Center (JRMC) in Pine Bluff on August 2. Specimens of serum and/or cerobrospinal fluid (CSF) from these patients had tested positive for SLEV at a reference laboratory. The public health response began by sending these specimens to the Centers for Disease Control (CDC) for laboratory confirmation. Meanwhile, the city-county mosquito control program increased spraying, beginning the following day. On August 5, the health department released a public health message to the press, noting the probable presence of the misquito-borne virus in the community and

Table 1. Facts on St. Louis Encephalitis for the South-Central United States	
Pathogen:	Flavivirus (Togaviridae)
Season:	July - October
Vector:	Culex pipiens-quinquefasciatus (common house mosquito)
Hosts:	sparrows, robins, pigeons, mockingbirds (humans incidental)
Incubation:	1-2 weeks in humans
Clinical Presentation:	asymptomatic (99%) symptomatic (1%): from mild fever or headache to encephalitis
Differential Diagnosis:	includes other viral central nervous system infections: echoviruses, herpes simplex, other arboviruses, rabies
Diagnosis:	IFA test for IgM in acute-phase serum/CSF or 4-fold rise in IgG in convalescent-phase serum
Treatment:	supportive
Prognosis:	mortality 5%-10% of symptomatic infections; sequelae < 10%

advising personal protective measures. The health department notified physicians in the Jefferson County area about the cluster of probable cases, and requested that cases or suspected cases be reported. Surveillance continued through the end of September.

Methods

For the purpose of this investigation, a case of SLE was defined as symptoms of encephalitis (fever or headache with confusion or other central nervous system dysfunction) in an Arkansas resident from July 1 to October 1, 1991; and laboratory evidence of acute SLEV infection.

Case finding relied primarily on alerted physicians. Physicians submitted sera and/or CSF specimens for SLEV testing, either to reference laboratories via local hospital laboratories, or to the CDC laboratory (Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, Fort Collins, Colorado) via the Arkansas Department of Health. The CDC laboratory, a research lab that offered assistance in testing during the outbreak, uses the IgM-capture, enzyme immunoassay (EIA)—considered the "gold standard." The reference laboratories used the immunofluorescent antibody (IFA) technique. All specimens positive by IFA were later confirmed by EIA.

At JRMC, two additional case-finding methods were used: 1) all CSF specimens obtained from patients hospitalized in July, August, or September without evidence of bacterial infection were tested for SLEV at the CDC laboratory; and 2) admission logs and medical charts from all hospital discharges and all emergency department and acute-care clinic admissions during the period July 1 to August 15 were reviewed for clinical presentations consistent with neuroinvasive SLE.

The denominator used to calculate the yield of SLE testing by the various case-finding methods was obtained from the two reference laboratories through which SLE cases were diagnosed (Vital Diagnostics, TX; Microbiology Reference Laboratory, CA) and the CDC laboratory.

Further studies in the Pine Bluff community included a seroprevalence study of residents in August and a seroprevalence and viremia study of birds and mosquitos in late August and early September.

Results

Twenty-eight Arkansas residents met the case definition for SLE. Twenty-one cases were found at JRMC, where physicians tested 76 hospitalized patients for SLE (Figure 1). Another four cases were found by physicians who submitted specimens from 18 patients hospitalized elsewhere in Arkansas. Physicians submitted specimens from 73 out-patients (20 in Pine Bluff and 46 elsewhere) but did not find any cases.

Three additional cases were found among 124 CSF specimens stored at JRMC. The three positive specimens were from patients who had had symptoms consistent with SLE (two were infants hospitalized in July and not been tested for SLE; the third was an elderly woman hospitalized in August and tested for SLE, but the acute-phase serum was negative.)

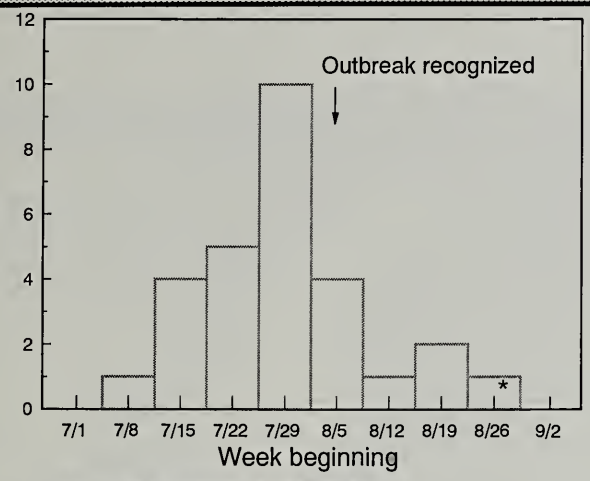
The record review at JRMC revealed 18 additional untested patients who had had symptoms consistent with SLE. Blood specimens were collected on only five

Figure 1. St. Louis Encephalitis Case-Findings Methods, Arkansas, 1991

Method	Patients Tested	Cases Number	Cases (%)
1. Testing by M.D.s - Pine Bluff	103	21	(20)
Inpatient	76	21	(28)
Outpatient	27	0	(0)
2. Testing by M.D.s - elsewhere *	64	4	(6)
Inpatient	18	4	(22)
Outpatient	46	0	(0)
3. Stored CSF Specimens--Pine Bluff	124	3	(2)
4. Medical Record Review--Pine Bluff	5	0	(0)
	296	28	(9)

* Based on specimens submitted to CDC or to the two reference labs through which cases were diagnosed.

Figure 2. Cases of St. Louis Encephalitis, By Week of Onset, Arkansas, 1991



* The only case not associated with Pine Bluff, AR.

of these, however, and none had serologic evidence of infection. Thus, no additional cases were found by this method.

Twenty-eight cases, then, were identified—24 at JRMC and four at other hospitals. Of the 24 patients at JRMC, 22 were tested by IFA (reference laboratory test), and all were positive except one (whose acute-phase serum was negative by IFA but whose CSF was positive by EIA).

Cases occurred from July 14 to August 28, 1991 (Figure 2). Twenty-six of the patients lived or worked in Pine Bluff; one was an out-of-state visitor who had been in Pine Bluff for less than two weeks; and one lived and worked in Clark County, AR, and had not visited Pine Bluff. Case patients ranged in age from three months to 85 years (Figure 3), with a median of 60 years. Sixteen (57%) were female, and 18 (64%) were black. Twelve (43%) had hypertension, nine (69%) of whom were over age 60.

The incidence for Pine Bluff was 44 per 100,000 overall; one census tract had seven cases (for a rate of 190 per 100,000). The 65-74 year old age group had eight cases (for a rate of 170 per 100,000).

By definition, all 28 persons experienced fever or headache plus confusion or other central nervous system disorder. Symptoms included dizziness or ataxia,[7] myalgia/arthralgia,[7] nausea or vomiting,[5] tremor,[4] slurred speech,[4] seizures,[3] and visual disturbance.[3]

Five (18%) of the 28 died within two months of onset of their symptoms. Their ages ranged from 54 to 75. One of these four had chronic myelogenous leukemia, but the others were not in poor health before their SLEV infections. Of the 23 survivors, three (13%) have residual symptoms one year later, including weakness, tremor, and arthralgia.

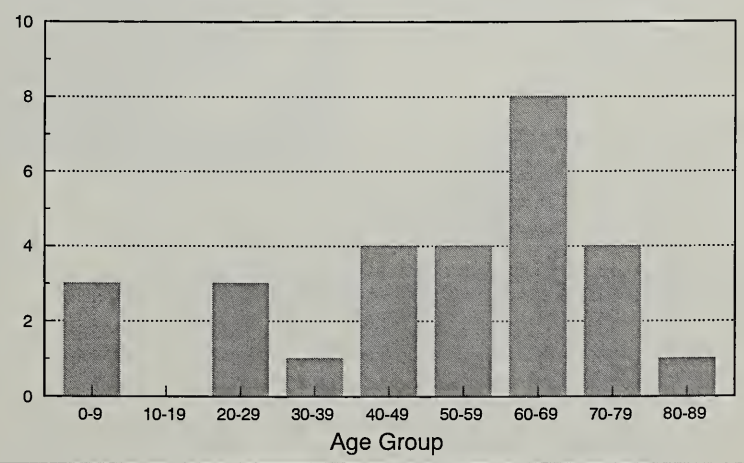
The serosurvey showed evidence of both old SLEV infection (predating the outbreak) and recent SLEV infection (outbreak-related) among 214 Pine Bluff residents, none of whom reported symptoms suggestive of SLE (A. Marfin et al., manuscript in preparation). The bird and mosquito studies showed that typical host and vector species were involved (R. McLean et al., manuscript in preparation).

Discussion

This outbreak of SLE is the first recorded in Arkansas. The case-patients involved are typical, based on comparison with other outbreaks that have shown age and hypertension to be risk factors for symptomatic infection.[3] The geographic clustering of cases seen in Pine Bluff is also typical compared with other outbreaks that have shown higher infection rates in lower socioeconomic areas, where living conditions offer less protection from mosquitos and more mosquito breeding sites.[3] Results of the serosurvey suggest that SLEV has been in Pine Bluff before. The sharp decline in cases within two weeks after recognition of the outbreak suggests that increased mosquito spraying and the public health advisory may have prevented additional cases in late August and September.

Why did the 1991 Arkansas outbreak occur? Previous studies suggest that SLEV is brought into a new community by migratory birds.[2,3] Many factors, however, are required to sustain transmission: a sufficient concentration of host birds, susceptible to SLEV and capable of a sustained viremia to transmit it to mosquitos

Figure 3. Cases of St. Louis Encephalitis by Age, Arkansas, 1991



that bite them; proper weather conditions for breeding a sufficient concentration of the Culex pipiens-quinquefasciatus mosquito vectors and for a sufficiently short "extrinsic incubation" (the time for the virus to get from the mosquito's gut to its salivary glands); and transmission of the virus from infected mosquitos to other, susceptible birds during the few other blood meals that a mosquito takes during the season.[2,3]

Will Jefferson County or Arkansas physicians see cases of SLE in 1992? Very possibly, although it is difficult to predict. Some outbreaks have continued over several seasons, while others have been followed by only sporadic cases or none.[3] It stands to reason that consecutive outbreaks of SLE depend upon the number of infected mosquitos and the number of non-immune persons exposed. The number of infected mosquitos depends upon the "over-wintering" success of the virus (in mosquitos or mosquito eggs or hosts), weather conditions for the mosquito (a wet, warm spring and a hot, dry summer are thought to be optimal), and the effectiveness of the city-county mosquito control program (the one in Pine Bluff has been considerably expanded in 1992). The number of non-immune persons exposed depends upon the extent of asymptomatic infections during the first outbreak, and the degree to which non-immune persons take measures to remove peridomestic mosquito breeding sites and avoid mosquito bites.

In deciding whether to test symptomatic patients for SLEV infection, Arkansas physicians should keep in mind the SLEV season (July through October). They should also consider that fever and headache are the most consistent findings, but there is "no pathognomonic profile of neurologic findings," according to Brinker and Monath.[2] Other arbovirus infections should be part of the differential diagnosis, and physicians may order an "arbovirus panel" (including tests for the California, western equine and eastern equine encephalitis viruses, as well as for SLEV) at little or no extra cost. On the basis of results of testing during the Arkansas outbreak (which involved two reference laboratories), the IFA test is quite sensitive. False-positive results are unlikely, unless the patient has had another flavivirus infection (dengue fever or Japanese encephalitis), or has received yellow fever vaccine.[2]

Recommendations

1. Physicians in Arkansas should consider SLE when a patient (especially an elderly and/or hypertensive patient) presents with fever and headache plus confusion or other neuroinvasive symptoms (e.g., seizure, tremor, ataxia, or cranial nerve dysfunction), with CSF findings consistent with viral infection. Given one reported outbreak in Jefferson County and previous outbreaks in Memphis, TN and in Greenville, MS,[8,9] it is reasonable for Arkansas physicians in the delta area to have a higher degree of suspicion.
2. Diagnosis requires both acute- and convalescent-phase sera. (A CSF specimen may also be submitted to test for IgM, but IFA diagnostic standards for CSF have not been established.) Preferably, the specimens should be sent for an arboviral "panel" of tests at a reference laboratory. (The Arkansas Department of Health laboratory does not provide testing.)
3. All cases of SLE should be reported to the Arkansas Department of Health (phone 1-800-482-8888). Prompt reporting may help to prevent further cases through public health advisories.
4. Persons inquiring about the risk of getting SLE should be advised that the SLEV is transmitted only by mosquitos and that most infections are asymptomatic. Nevertheless, reasonable precautions to lessen exposure to mosquitos are: mend household screens; remove potential mosquito breeding sites around the yard (e.g., tires, cans, plastic containers—anything that can collect even a small amount of water); and wear mosquito repellent during evening hours spent out-of-doors.

Acknowledgments

This outbreak investigation was conducted by the Arkansas Department of Health and the Division of Vector-Borne Infectious Diseases of the Centers for Disease Control, with assistance from Jefferson Regional Medical Center in Pine Bluff, AR. The authors owe special thanks to: Dr. Tom Ed Townsend, Dr. Walter Wilkins and medical records, laboratory, and emergency department personnel of Jefferson Regional Medical Center; Beth Earlywine, Donetta McGriff, Mark Townsend, Steve Waldren, and Randy Stegall at the Arkansas Department of Health; physicians of SLE case-patients; and physicians who submitted specimens from suspected cases.

References

1. CDC. St. Louis encephalitis outbreak - Arkansas, 1991. MMWR, 1991; 40:605-7.
2. TP Monath. St. Louis encephalitis. American Public Health Association: Washington, D.C., 1980.
3. JP Luby. St. Louis Encephalitis. Epidemiol Rev, 1979; 1:55-73.
4. MB Rennels. Arthropod-borne virus infections of the central nervous system. Neurologic Clinics, 1984; 2:241-54.
5. RJ Whitley. Viral encephalitis. N Engl J Med, 1990; 323:242-9.
6. JF Day. Epidemic proportions. Natural History, 1991; July:50-3.
7. TP Monath, TF Tsai. St. Louis encephalitis: lessons from the last decade. Am J Trop Hyg, 1987; 37;40s-59s.
8. JS Levy, H Carver, IK Moseley et al. Epidemiologic features or the St. Louis encephalitis epidemic in Memphis, Tennessee, 1975. South Med J, 1978; 71:633-7.
9. KE Powell, DL Blakey. St. Louis encephalitis: the 1975 epidemic in Mississippi. JAMA, 1977; 237:2294-2298. ■

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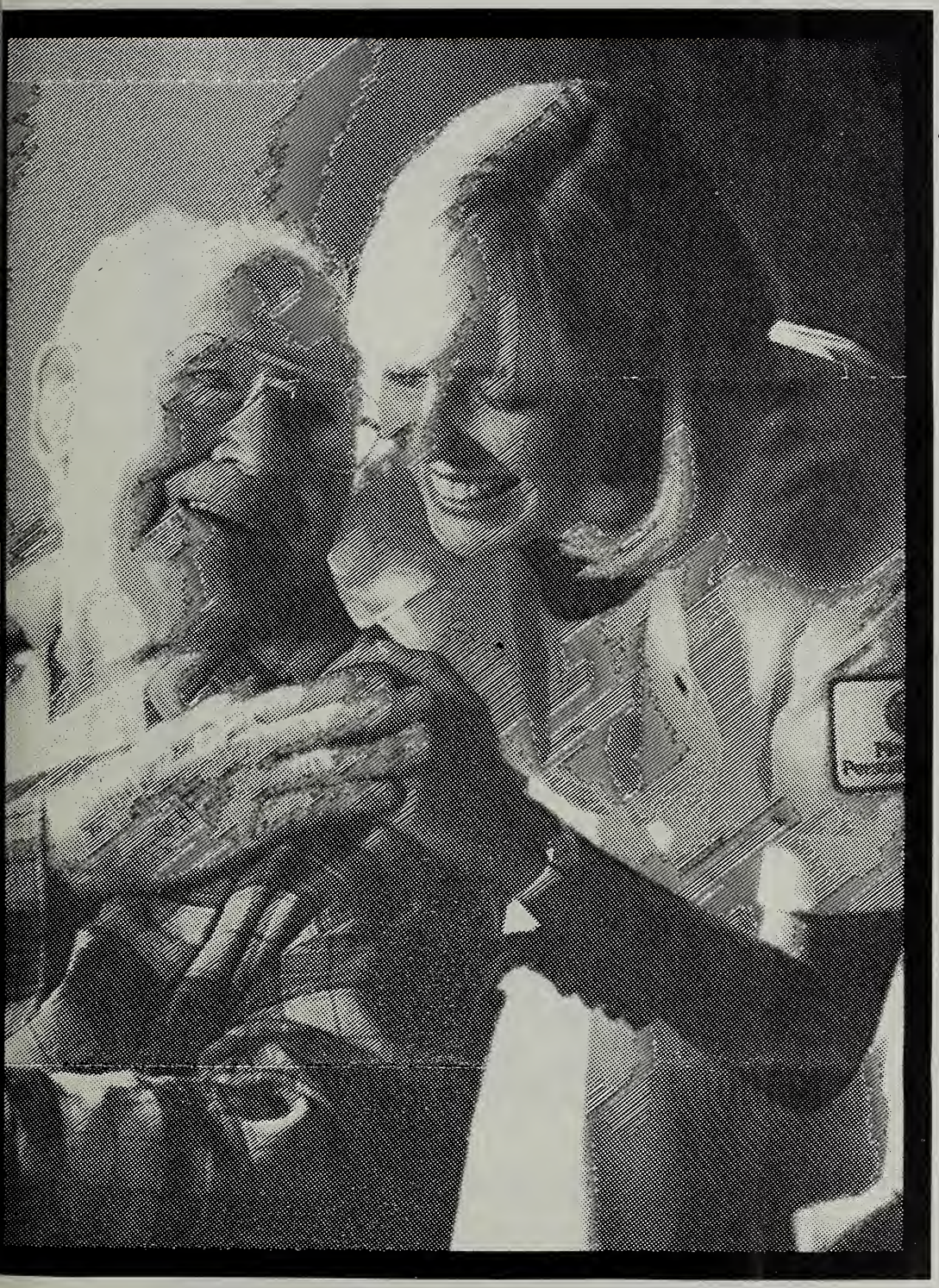

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Treatment of Cervical Dystonia (torticollis) in Adults with Botulinum A Toxin

W. Steven Metzer, M.D.*
Tonya Jenkins, M.D.**

Dystonias can be classified by etiology (idiopathic or symptomatic), by age of onset (childhood, adolescence or adult), and by anatomical involvement (focal, segmental or generalized). Cervical dystonia (torticollis) is one of the most common focal dystonias. We describe our experience in the treatment of 15 consecutive cervical dystonia patients by chemodenervation with botulinum A toxin (BOTOX), with significant improvement being objectively measured. Botox is accepted as a safe and efficacious modality for the treatment of cervical dystonia.

When dealing with involuntary hyperkinetic movement disorders (dyskinesias), it is helpful to first decide what phenomenon one is observing. Movement disorders can be classified as akathisia, tremor, chorea, athetosis, dystonia, myoclonus, tics or ballismus. Most movement disorders can be categorized phenomenologically using this classification.[1]

Dystonia is characterized by involuntary, sustained muscle contraction, resulting in twisting and repetitive movements with abnormal postures, often with painful torsion spasms. Dystonias can be classified by etiology (idiopathic or symptomatic), by age of onset (childhood, adolescence or adult), and by anatomical involvement (focal, segmental or generalized). A pathological cause for dystonia can be established in about 40% of patients with childhood onset, in 30% with adolescent onset, and in 13% with adult onset. A pathological cause can be identified in about 45% of those with generalized or multifocal dystonia, but only in about 10% of those with focal dystonia. Childhood and adolescent onset dystonias are frequently familial (autosomal dominant with variable penetrance), while adult onset dystonias are usually sporadic.[2,3] While generalized dystonia is uncommon, all forms of dystonia taken together probably have a prevalence of 300-400 per million.[3] Dystonias commonly coexist with other movement disorders.

Cervical dystonia is one of the most common focal dystonias, with an estimated incidence of three per 10,000.[2] The term "spasmodic torticollis" is typically used to refer to all types of cervical dystonia, although most patients have laterocollis, retrocollis, or anterocollis in combination with torticollis, depending on which muscles are involved. Pain is present in about 67% of cervical dystonia patients. About 70% have a coexistent tremor. Significant psychopathology is present in about 19% of cervical dystonia patients, with depression being most common.[4] About 20% of cervical dystonia patients experience spontaneous remission in the first five years of their illness; the remission is sustained in about half these individuals. Dystonia eventually becomes multifocal or generalized in about 30% of cervical dystonia patients.[5]

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** Dr. Jenkins is with the Neurology Service, McClellan Memorial Veterans Administration Medical Center, and the Department of Neurology at the University of Arkansas for Medical Sciences, Little Rock, Arkansas.

We describe our experience in the treatment of 15 consecutive cervical dystonia patients with botulinum A toxin (BOTOX) chemodenervation.

Methods

These patients consisted of 15 consecutive cervical dystonia patients (8 men; 7 women) referred for treatment at the McClellan VAMC and the University of Arkansas for Medical Sciences. Mean age was 50.2 years (range = 33-73 years; SD = 14.4). Mean duration of cervical dystonia was 9.7 years (range = 1-24 years; SD = 7.5). Five patients had undergone previous surgical treatment, including peripheral denervation, dorsal rhizotomy and Jannetta procedure. Only one patient had received a single previous BOTOX injection treatment at Columbia University in New York.

All patients were scored before and 10-21 days after BOTOX injection using the Columbia Torticollis Rating Scale.[6] Dystonic cervical muscles were injected at selected, individualized, multiple sites with total doses of 100-200 units of BOTOX (almost all patients received a total dose of 150 units of BOTOX).

Results

Of the 15 patients, 11 were improved, three were unchanged and one was worse after chemodenervation with BOTOX. Mean pre-injection score on the Columbia Torticollis Rating Scale was 20.9 (range = 6-34; SD = 10.1). Mean post-injection score was 9.9 (range = 0-33; SD = 10.1). This improvement is significant ($t = 2.989$, $df = 14$, $p < 0.005$).

Improvement index was calculated by dividing the change in score by baseline score, representing change from baseline. This could range from -1 (complete resolution) to 0 (no change) to +1 (twice as worse). Mean improvement index was - 0.5 (representing 50% improvement).

Discussion

As noted, adult onset focal dystonias are idiopathic in over 90% of cases.[2,3] Limited evaluation is necessary for adult onset cervical dystonia. Serum ceruloplasmin determination and brain magnetic resonance imaging (MRI) are suggested. Additional investigation, such as electromyography, cervical MRI, and other tests may be indicated in selected cases.

Prior treatment of cervical dystonia has consisted of surgery (thalamotomy; selective myotomy; peripheral denervation; Jannetta procedure; spinal cord stimulation) and treatment with a plethora of drugs. In one publication, 38% of patients were reported to improve after selective cervical rhizotomy.[4] Myotomy usually produces about a 50% improvement, but is a major procedure.[7] The most commonly used drugs are high-dose anticholinergic treatment, L-DOPA, benzodiazepines, baclofen, dopamine receptor antagnosists and dopamine depleting drugs.[3,4] These drugs are of some benefit in as many as 50% of patients, but the improvement is usually modest and side effects can be significant.[7] Chemodenervation with BOTOX for cervical dystonia has been discussed in eight published reports describing 434 patients. All studies reported significant benefit in 53-90% of patients.[7] Pain is often dramatically improved, even when head control is not.[8] This has led the Therapeutics and Technology Subcommittee of the American Academy of Neurology to conclude: "BOTOX is accepted as a safe and efficacious modality for the treatment of cervical dystonia."[7] Obviously, this treatment is not indicated for all cervical dystonia patients, not all improve, and it is not a panacea.

The effect of the injections usually lasts 3-6 months. BOTOX is generally well tolerated. Allergic reactions are almost unheard of. Occasional patients develop transient "floppiness" of their necks, which can usually be easily treated with a collar. About 10% of patients develop transient dysphagia or flu-like symptoms, which are usually mild. Occasional patients have been noted to eventually develop antibodies to the toxin, rendering it ineffective.[7,8] Chemodenervation with BOTOX for cervical dystonia should be performed only by physicians knowledgable in dystonia and properly trained in the use of the toxin.

Acknowledgements

The opinions and views expressed herein are those of the author and not of the Department of Veterans Affairs.

References

1. Fahn S. Involuntary movements, in Rowland LP (ed): Merritt's Textbook of Neurology, Ed.8. Philadelphia, Lea & Febiger, 1989, pp 48-50.
2. McGeer EG, McGeer PL. The dystonias. Can J Neurol Sci, 1988; 15:447-483.
3. Marsden CD, Quinn NP. The dystonias. Brit Med J, 1990; 300:139-144.
4. Jankovic J, Leder S, Warner D, Schwartz K. Cervical dystonia: clinical findings and associated movement disorders. Neurology, 1991; 41:1088-1091.
5. Jahanshahi M, Marion M-H, Marsden CD. Natural history of adult-onset idiopathic torticollis. Arch Neurol, 1990; 47:548-552.
6. Greene P. Rating dystonia: monitoring outcome of injections, in The Use of Botulinum Toxin in the Treatment of Focal Dystonia. New York, Columbia University College of Physicians & Surgeons, 1990, pp 15-41.
7. Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Assessment: the clinical usefulness of botulinum toxin-A in treating neurologic disorders. Neurology, 1990; 40:1332-1336.
8. Greene P. Use of botulinum toxin in the treatment of torticollis, in The Use of Botulinum Toxin in the Treatment of Focal Dystonia. New York, Columbia University College of Physicians & Surgeons, 1990, pp 77-82. ■

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- American Association of Retired Persons (AARP)
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- American Heart Association, Arkansas Affiliate
- American Lung Association of Arkansas
- Arkansas Academy of Family Physicians
- Arkansas Advocates for Children and Families
- Arkansas Association of Area Agencies on Aging
- Arkansas Association of Home Health Agencies
- Arkansas Blue Cross and Blue Shield
- Arkansas Cancer Research Center
- Arkansas Dermatological Society
- Arkansas Gerontological Society
- Arkansas Health Care Association
- Arkansas Hospital Association
- Arkansas Impact
- Arkansas Medical Society
- Arkansas Nurses Association
- Arkansas Opthalmological Association
- Arkansas Optometric Association
- Arkansas Perinatal Association
- Arkansas Pharmacists Association
- Arkansas Public Health Association, Inc.
- Arkansas Society for Public Health Education
- Arkansas Speech-Hearing-Language Association
- Arkansas State Board of Health
- Arkansas State Dental Association
- Arkansas Thoracic Society
- Arthritis Foundation, Arkansas Chapter
- Campaign For Kids Coalition
- College of Medicine Faculty, University of Arkansas for Medical Sciences
- CARTI
- Governor's Advisory Council on Aging
- Lost Chord Club of Central Arkansas
- March of Dimes Birth Defects Foundation, Arkansas Chapter
- Medical Equipment Suppliers Association of Arkansas
- Mental Health Council of Arkansas
- National Association of Social Workers, Arkansas Chapter
- The Presbytery of Arkansas
- Presbyterian Urban Council
- Retired Senior Volunteer Program
- United Methodist Church, Little Rock Conference
- United Methodist Church, North Arkansas Conference
- Youth Home, Inc.

OR ONE OF THESE?

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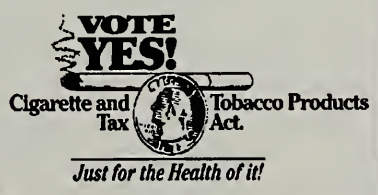
(Think about it.)

This message brought to you by your friends at the Coalition for a Healthier Arkansas, Russ Rawn Treasurer



Coalition for a Healthier Arkansas

Steering Committee

William N. Jones, M.D., Chairman

Taxes on Cigarettes Are Low in Arkansas

Arkansas now ranks behind 29 states and the District of Columbia in the excise or user tax it charges on each pack of cigarettes sold.

So Arkansans not only pay the lowest average local taxes in the nation (municipal, county and improvement district taxes, according to the Arkansas Municipal League), but Arkansas smokers - who once paid half their cigarette dollar to state and federal taxes - now pay just 25% of it to tax.

The rest of that cigarette dollar further enriches tobacco conglomerates, now highly diversified because of their increasing difficulty in recruiting smokers to replace the thousands the tobacco industry loses daily. Smokers now either find the will to quit or, tragically, their smoking habit eventually "quits" them.

The Coalition for a Healthier Arkansas (CHAR), in an initiated Act first announced March 27, 1992, is seeking to have Arkansas voters, on November 3, approve an increase of 25 cents over the state's current 22-cent tax on a pack of cigarettes.

CHAR spokespersons say the 25-cent excise surtax merely restores state's tobacco tax rate to its previous level before major tobacco companies began raising prices for cigarettes and other tobacco products in the 1970s.

Currently, Hawaii has the highest state tobacco tax - 46 cents a pack. Hawaii is followed by Connecticut's 45-cent tax and Minnesota's 43-cents (Table 1).

Tobacco-producing states - Virginia, Kentucky, North and South Carolina predictable are bunched at the bottom of tobacco-taxing states.

None charges more state tax than seven cents a pack. Virginia smokers pay just 2.5 cents tax on a 20-cigarette pack plus the 16-cent federal excise tax.

When Arkansas, for the first time in years, raised its cigarette tax in 1991 from 21 to 22 cents, the revenues were earmarked to support transportation services for elderly Arkansans.

When Arkansas voters approve CHAR's proposal November 3, Arkansas smokers will pay a total 47 cents state tax per pack. Half of the $68 million that added tax yields will match federal Medicaid funds to provide Arkansas a $136 million more to provide medical care for elderly, indigent Arkansans.

Availability of state funds for such medical care has been seriously jeopardized in recent months. And many lifelong smokers are among indigent patients now in dire need of medical treatment for such tobacco-related illnesses as cancer, heart disease and emphysema.

Since the actual over-the-counter price of cigarettes in Arkansas has risen dramatically through the years, some smokers think most or all of these increased costs are the result of higher taxes. Here's a breakdown of how much cigarettes have increased in cost and how much of that increase price was state taxes.

Cigarette Taxes in Arkansas

1971	17 3/4 cents per pack
1982	21 cents per pack
1991	22 cents per pack

Cigarette taxes have increased 4 1/4 cents in 20 years.

Actual cost of a pack of cigarettes

1971	75 cents per pack
1991	$1.75 per pack

Cigarette prices have gone up $1.00 in 20 years.

Table 1. Taxes Charged on Cigarettes by State

Hawaii	46 cents	Massachusetts	26 cents
Connecticut	45 cents	Michigan, New Hampshire	25 cents
Minnesota	43 cents	Delaware, Kansas	24 cents
Texas	41 cents	Oklahoma, South Dakota	23 cents
New Jersey	40 cents	Arkansas	22 cents
New York	39 cents	Colorado, Louisiana	20 cents
Maine, Rhode Island	37 cents	Arizona, Idaho, Mississippi, Montana, Ohio, Vermont	18 cents
Iowa	36 cents	West Virginia	17 cents
California	35 cents	Alabama	16.5 cents
Nevada	35 cents	Maryland	16 cents
Washington	34 cents	Indiana	15.5 cents
Florida	33.9 cents	New Mexico	15 cents
Pennsylvania	31 cents	Missouri, Tennessee	13 cents
District of Columbia, Alaska, Wisconsin, Illinois	30 cents	Georgia, Wyoming	12 cents
North Dakota	29 cents	South Carolina	7 cents
Oregon	28 cents	North Carolina	5 cents
Nebraska	27 cents	Kentucky	3 cents
Utah	26.5 cents	Virginia	2.5 cents

COALITION FOR A HEALTHIER ARKANSAS

P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

Dear C.H.A.R. Campaign Chairman:

I have read about the upcoming campaign for an initiated act to further tax tobacco sales in Arkansas, and I want to help all I can before the November 3 vote.

Please contact me as a volunteer to:

__ Display yard signs at my home or office.

__ Help set up and direct a county campaign headquarters.

__ Participate in a campaign speakers' bureau for civic clubs and other community groups in my vicinity.

Enclosed please find my check (or money order) in the amount of:

$1000_____ $750 _____ $500_____

$250 _____ $100 _____ $_____

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ (day) _____ (evening)

CHAR Succeeds in Petition Goal

The Coalition for a Healthier Arkansas (CHAR) announced July 3, 1992, on the steps of the State Capitol they had filed more than 70,000 signatures with the Arkansas Secretary of State's office calling for an election to decide if Arkansans want to charge smokers an additional 25 cents tax per package of cigarettes beginning in 1993.

The boxes of petitions supposedly arrived inside an ambulance and under the care of three pre-school aged children as Dr. Bill Jones, chairman of the drive, called this a children's health issue for the state. Then he set the tone for the upcoming fight between CHAR and the big tobacco interests by telling the crowd of supporters on the Capitol steps that the boxes were empty.

"Based on what the big tobacco companies have done in other states with legal and illegal dirty tricks to keep similar efforts off the ballot, we were afraid we might face an injunction if we filed on a legal holiday. Therefore, the actual petitions were delivered to the Secretary of State's office earlier this week without fanfare, avoiding legal harassment by one of the state's largest and most successful law firms which is heading up tobacco's battle in Arkansas," Dr. Jones said.

He went on to declare that the people in Arkansas need to know, "You can't trust big tobacco."

This theme was evident in his speech as he dramatically asked the crowd, "Who can you trust, Big Tobacco or your family physician? Big Tobacco companies or your friends at your local hospital? Big Tobacco companies or the people who operate the Senior Citizen Centers? Big Tobacco companies or the Cancer, Heart, Lung and Arthritis organizations in Arkansas?"

In addition, large signs were carried by supporters asking the same question by listing the names of 50 coalition members vs. Big Tobacco and Big Law Firms.

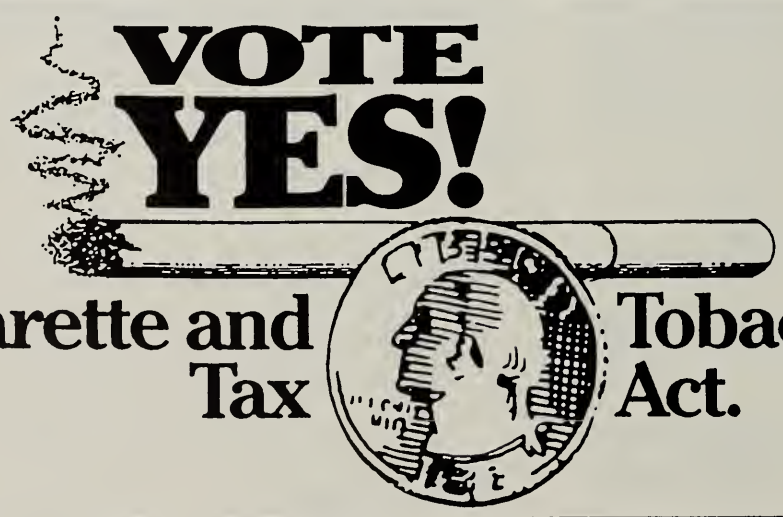
As an example of tobacco's "lack of truthfulness," Dr. Jones announced to the gathering crowd he had learned that the Philip Morris Tobacco Company had been fined $125,000 by the California Election Commission for illegally failing to report $1.8 million in non-monetary contributions toward their failed efforts to defeat Proposition 99 - a similar cigarette tax - in 1988.

The fine was the fifth largest ever levied by the California Fair Political Practices Commission.

Estimates indicate that about $68 million would be raised each year from the new tobacco tax. About $34 million - or one half the proceeds - would be used for federal matching funds, used to pay healthcare providers for the treatment and care of patients who are Medicaid-eligible.

Other funds would be earmarked for senior citizen services, education for young people on the abuse of drugs, alcohol and tobacco, aid to families and abused children and to provide cancer research funding in Arkansas.

Additionally, CHAR supporters say that the increased cost of cigarettes will discourage many young persons, especially teenagers, from starting to smoke. Research shows that 90% of current smokers began their addictive habit before age 19 and 60% began by age 14. Other research shows a measurable decrease in those who begin smoking if the price of cigarettes is raised.



Cigarette and Tobacco Products Tax Act.

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P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

The following physicians have contributed to the Coalition for a Healthier Arkansas, an effort endorsed by the Arkansas Medical Society. If you would like to add your name to the iist of supporters, complete the pledge card on the bottom of page 137 and return it to CHAR.

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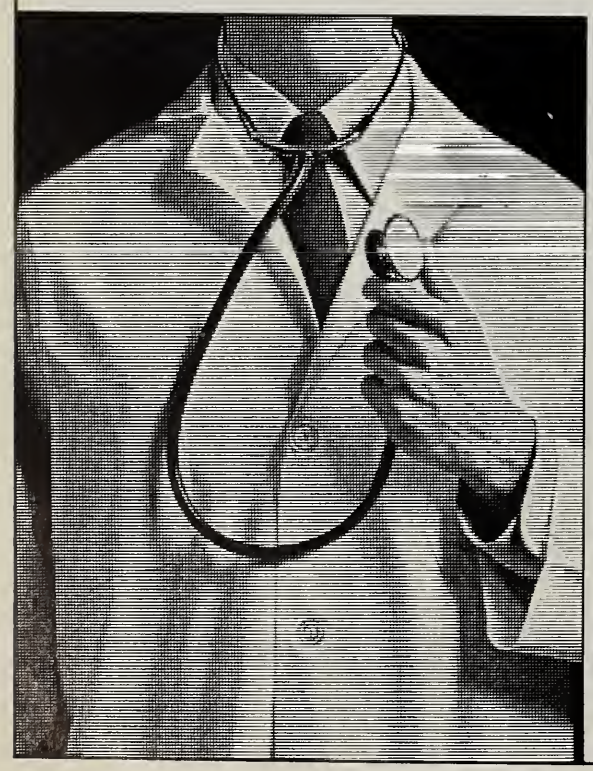

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In A Heartbeat

David E. Reiser, M.D.*

On July 3, 1991, Dr. Rick Sims, a second-year resident in Anesthesiology at the University of Colorado Health Sciences Center, was found dead in a call-room in University Hospital. The cause of death was an overdose of Sufenta, a potent intravenous narcotic, which he had self-administered. In the ensuing days, the event quickly became a media circus, with sensational accounts of his addiction and death saturating the newspapers and local TV news channels. What these accounts failed to address was the human dimension of the tragedy. Dr. Sims was a physician of intellect, charm, and great promise. He was 28 when he died. He left behind a wife, Beth, also 28, and two young daughters, Jennie, age 2 and Betty, four months. He left parents who grieve deeply for him. And he left his teachers and peers at the University of Colorado in a state of bewilderment, grief and shock. Everyone involved felt a gnawing sense of helplessness and guilt. How could his addictive illness have advanced so far without detection? Why had no one intervened? Once again, a young physician of promise was dead from the twin diseases of alcoholism and drug addiction. It was not the first time, and it will not be the last.

In the months since her husband's death, Beth Sims has spoken on several occasions to groups of medical students, house officers and physician spouses. Her message is straightforward: tragedies such as Rick's are not inevitable. Addictive disease, while a serious problem, does not have to turn into a deadly one. A person suffering from addiction no longer has to face an inevitable downward spiral of hopelessness, loss, public disgrace and the end of a medical career. Help is available, and people do recover. Beth makes the point, moreover, that no professional license is worth a human life.

In order to recover, however, afflicted physicians and their families must first come out of the shadows and accept help. This is something that virtually every addicted physician resists stubbornly. To resist help is in the very nature of the disease. Recovery almost always begins with detection and confrontation by family, colleagues, and friends. When such a confrontation can not be effected (and it is seldom accomplished easily), addictive disease will invariably progress and get worse.

With these realities in mind, Beth agreed to meet with the Colorado Physician Health Program (CPHP) for an interview. We initially wondered if we should publish the interview under a pseudonym. But in the end, with Beth's agreement, we decided to use real names. So much notoriety, innuendo, and media insensitivity had already surrounded her husband's death that we all decided it would be more helpful, and healing, to publish the interview without disguise.

We met Beth at her place of employment. She has a striking presence - a petite, dark-haired woman with luminous, cobalt-blue eyes, quick, decisive gestures, and a firm no nonsense handshake. She approached the interview with friendliness and just a hint of formality, but her grief and pain quickly became apparent.

CPHP: Why don't you begin wherever you feel it is appropriate?

Beth: They found Rick in a call-room at University Hospital on July 3 and...he was dead. He had overdosed

* Dr. Reiser is the editor of *The Colorado Physician Health Program Newsletter*, Denver, Colorado.

on Sufenta. He had had a problem for a while. I'd caught him. He'd come home eight or nine days before, late, and told me that he had a problem. Like all addicts, he said he could handle it and it wasn't a big deal. He thought he could lick the problem if I'd support him. I thought about asking him to leave the house. But I didn't. Even now, I'm not sure I would have done it any differently.

I had found a needle in the bathroom under a throw-rug nine months before that. That time it was morphine. I had caught him one other time, using Versed. There were a number of other times that I suspected it, but couldn't prove it. And of course like all addicts, he lied.

" I kept hoping that, if I just didn't look, it would somehow all go away. "

We do know, in retrospect, that quite some time before all this, he'd been at a CPHP meeting. It wasn't a confrontation directed at him. It was one of those orientation session for residents that they do. Rick was there. Several people from CPHP remember him. But, somehow, when we had our last major confrontation, eight or nine days before his death, CPHP never came up.

CPHP: Which is one of the problems with this illness. The disease fights to survive at all costs. When, looking back on it, do you think Rick's problem began?
Beth: Maybe college. Maybe even high school. I never saw anyone who could drink as much as he could and still appear to be sober. It would be nothing for him to have three or four huge eight ounce tumblers of Jack Daniels and coke over ice on a given evening. He was doing that even back in college. Almost every night. It never seemed to affect him. One time he said to me, "I'm not an alcoholic because I only like Jack Daniels and if they don't have that, I don't drink at all." And, for many years, that was true.

I first recall really being troubled by his drinking when he was in his third year of medical school. I went with a friend to a self-help group at that point. Actually, I started going because I was working with a woman whose husband had a definite problem, and she wanted me to bolster her resolve, so she wouldn't have to go to the meetings alone. I said, "Sure, I don't have any problem with going to those meetings. Rick is always studying, or out playing poker with his friends, anyway."

From the outset, Rick hated my going there. Because, you know, it was obvious what effect all this had on me. Even though I had gone not consciously thinking that I was there because Rick had a problem, I would go and all these women would be sitting around, talking about how to better themselves and the kind of a positions they were in because of their alcoholic spouse, and it was easy for me to begin to decide, "Well, maybe Rick is an alcoholic, after all." He drank too much. Too often. Way too much. And it never appeared to affect him at all. How can you drink that much and not get drunk? Unless you have a problem. What I learned at the group began to open my eyes.

Ultimately, I quit going after several months. It was a summer thing. I had had the time and told myself in the fall that I had gotten too busy. But I had also begun to sense that it was causing me more problems in some ways than it was solving. It was rocking the boat, to say the least. It certainly threatened Rick. So, I quit going and a short time later I got pregnant with our older daughter, Jennie. To be honest with you, I started to feel like a hypocrite. Here I was, getting pregnant. If I really was acknowledging that this man was an alcoholic, then why was I going out and getting pregnant? The truth is, for why I quit going, is that, in the end, it was just easier...

CPHP: It sounds like you and Rick both said a silent prayer that, maybe, if you just hoped hard enough, the problem would somehow recede and go away, and you could go on with the life you had planned for yourselves.
Beth: That's right. That's exactly right. You just hope that it will all go away... So, that's what we did and nine months later, we had a baby. It happened real fast, too. I was pregnant within a month of starting to try.

You know, I think part of the problem was, for so long Rick was so lucky. He was lucky and charming. I remember, he was pulled over for a DUI about three months before he died. He was 1/100th of a point under the legal limit... So, they let him sit there for several hours until he was legal and then let him go. No ticket. No reprimand. If it had been me, I'd have been ticketed. Maybe put in jail! But Rick seemed to be charmed. He'd always squeak out of trouble.

CPHP: Do you sometimes wonder, if Rick hadn't been such a Golden Boy, if he hadn't been so graced, and charming...
Beth: That he might still be alive? All the time! Or if I'd pushed the point more. I feel guilty. His parents feel guilty. We all let him squeak by. He was the luckiest

person. He was truly charming. And he always got away with it - always. Until he didn't get away with it, and it was too late. You can't help wondering what the implications were, of your letting him get away with it, so many times, even though at the time you thought you were doing it because of his career, because this time he was really going to try. You thought you were doing it out of love. And, in a way, you were. Doing it out of love.

And now, I've got a daughter who is just like him. It's really spooky sometimes. She has exactly the same traits he had.

CPHP: And you're worried that...
Beth: Positively! I mean, what am I going to tell these kids about their father? At some point they have to know. Fortunately, she's only three. I don't have to tell her for a while. But, yeah, she scares me. She works me, and charms me, just like he did.

But getting back to Rick: I was about three months pregnant with our younger daughter, Betty, when I caught him with the needle the first time. He was near the end of his internship. It was morphine. I remember wondering, "Why would an intern have morphine?"

I was in the powder room and I remember that I told myself I was just neatening things up. So, I moved a throw-rug and found it. But I think I'd gone in there looking. He wasn't acting right that evening, weaving, slurring his speech a little... Oh, I remember! He'd come down to the laundry room that evening, unusually cheerful. I was folding clothes and he asked if he could help. I didn't even think he knew where the laundry room was! This was most definitely not normal. "Uh uh," I said to myself. "What's wrong?" He was standing there smiling, weaving. So, I discovered the needle that night and confronted him.

"What's this doing in the bathroom?" I said.

And he lied to me.

I remember, I was incensed. Incensed, and hurt and angry. And I remember - he was scared. I threatened to kick him out that night. To leave him. And I was serious. I was going to tell his parents. I was going to tell the whole world. And now, I think, if only I had. If only I'd followed through on that threat, I wonder what might have happened. Would it have turned out differently?

And he told me, he promised me - and this would be the only promise he would ever break in the 12 years I knew him - he promised me that if he ever did it again, he would move out.

The second time I caught him, I said, "That's it! You are out of here! I don't want your stuff here. I am not raising my children in this kind of environment! Pack your bags and get out!"

But he pleaded.

"No," he said. "I want to stay. We can work this out. I want to do something about this. Together. I know we can handle it if we just stick together."

How do you ignore that? When this is the person you love? This is the father of your children. And you so desperately want to believe that it's true.

So, he promised, once more. And that was the last time I caught him. It was eight days before he died.

I remember, we talked that night about Narcotics Anonymous. He was going to solve this problem. We would do whatever it took.

But I also recall something else from that night. Something very disturbing. I had found another needle. It was a real small gauge needle. And I had called him at the hospital and confronted him.

"You'd better get your story straight," I said. "Because I think you've been lying to me."

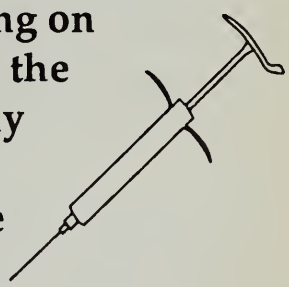
I remember that he said he'd be right home, and it ended up being an hour and a half. He said he'd just been driving around. But you know-this is terrible, but I think he needed the time to shoot more drugs before he was emotionally prepared to face me that night.

He came home, anyway, that much later, and said, "Beth, I think I've got a serious problem."

For the first time he said he was willing to do anything. He was willing to go to counseling. He was willing to go to Narcotics Anonymous. He knew he had a really serious problem and he was finally ready to confront it.

He was full of sincerity and contrition that night...

" He just couldn't hang on to the reality of where the addiction was actually taking him. Where it would end. And where it did end. "

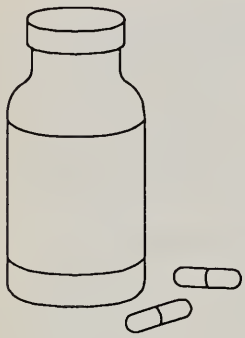


But the next morning, it was a whole different story. The denial, the defensiveness all came back.

To be honest with you, up to the very end I don't think I had any idea of how really serious this situation had become. I kept hoping that, if I just didn't look, it would somehow all go away.

CPHP: It's very possible that he was feeling the same emotions himself. If he just shot up one last time, and gave himself a few more precious hours of psychological peace, then, in the morning, he'd find the strength and resolve to lick the problem, for once and for all.

Beth: That morning, anyway, after all the promises of the night before, he started to back-peddle. I remember he was really concerned about losing his career. I mean - that was a big deal! He didn't want to teach high school chemistry or work in a lab. He couldn't imaging any life, other than being a doctor. And so on and so forth. And in truth, he'd always wanted to be a doctor. Since he was a kid. He never ever wanted anything else. So, in the end, I relented on my threats. One last time. And then, a week later, he was dead.



" ...you're scared. You don't know who can really be trusted when someone suffers from this disease. "

CPHP: Were you surprised by his death?
Beth: Yes and no. It wasn't completely unexpected. When his Chairman phoned me, he asked me if he could come over and talk with me, that something had happened to Rick. I knew it must have something to do with drugs. I didn't know if he'd been caught stealing them, or if he was dead. I admit, the thought did cross my mind. But, no, deep down I wasn't surprised.

CPHP: How has it been for you since Rick's death?
Beth: There are good days and bad days. If I think only about today, it's easier than if I think about the things that will never be. I always wanted a 50th wedding anniversary. We wanted another baby. That will never happen. I mean, I could have another baby, but **we** were going to have another baby.

CPHP: You still miss him a lot.
Beth: Every day! Every minute! And some days, I get really angry and I think, "If I had to have him back the way he was, lying to me, that...I wouldn't want him..." And then I think, "Oh yes I would!" I realize that I'd take him back for an hour. For a minute. Forever. Because - he didn't know. He just didn't know. It was too unbelievable that this was really happening to him. That his life was ending this way, when he'd had so much going, so much promise. When he was so young. Yet - how could it ever happen, that anybody so bright would not know? I'm still not sure I understand it, really.

CPHP: You know, it hasn't been that long.
Beth: Things stick out.. Picking out the casket was horrible. I think that anybody who has an addiction, or contemplates suicide, should have to go visit a funeral home and pick out a casket for someone they love. It's an incredibly cruel thing to do to somebody. The decisions I had to make. Was I going to bury him or cremate him? I mean, I knew that everyone dies. But, to die at 28, with such an incredibly bright future ahead of him. Somebody so lucky. How could it happen to him?!

CPHP: This is still pretty painful for you, bringing all this up again.
Beth: Yes. But in an odd way, it helps. It's something you have to go through.

CPHP: It is very much appreciated. But let me ask, while we're on the subject, why do you do all these things? Speaking to medical groups? Giving interviews such as this one?
Beth: Because nobody should have to go through this. Nobody should have to do this. Nobody should have to bury their 28 year old husband, because they didn't know what addiction really does.

And that was me. I didn't know. And if Rick knew how serious this whole thing was, he either didn't want to believe it. He just couldn't hang on to the reality of where the addiction was actually taking him. Where it would end. And where it did end. Nobody should have to go through that.

CPHP: If somebody out there reads this article, someone who is addicted, or someone who loves someone who is addicted, and you could tell them one thing - what would that be?
Beth: That there are more important things that losing your medical license. Like, losing your life.

CPHP: There's a bit of "what if" in this next question, but, for the reader - knowing what you know now, are there things you wish you could have done differently?

The Arkansas Medical Society Physicians' Health Committee is interested in the well being of Arkansas physicians. Through effective intervention, treatment referral and monitoring of health conditions, Physicians' Health Committee's services enable physicians to continue to deliver safe and effective patient care.

Beth: You have to be very careful when you allow your mind to start with the "what if" scenarios. It can be really dangerous. That leads to guilt. To the useless pain and the really dark times. And yet, you can't help asking yourself, "What if...?" I would ask myself, even if you didn't.

Let's see: Given what I now know, I wish I would have called his Chairman. I didn't know about CPHP. If I could have had two things, and if I could go back, that's what I would have done - called his Chairman, and called CPHP.

CPHP: So, you think that, maybe if word gets out more about CPHP, so that people have it firmly in their minds that it's there...
Beth: If I'd known about it, and if I'd really believed that it was anonymous, and was really safe, I would definitely have called. Over the last year, I thought about calling any number of people, any number of times. But you're scared. You don't know who can really be trusted when someone suffers from this disease. I didn't know who was safe. And, in retrospect, I have to say one more time: I really didn't know how unimportant a medical license really is.

CPHP: Is there anything about the system of education that Rick was a part of that you think should change?
Beth: I think that maybe some people with this disease should think twice about Anesthesiology as a specialty. I imagine that Rick wouldn't agree with that. But maybe, for him, it was just too dangerous. At some point, you have to be able to stand up for yourself. You have to be able to say, "Maybe Anesthesiology isn't a good thing for me, with my disease. Maybe it's too dangerous for me to go into."

I think mandatory drug testing might not be a bad idea. Six months ago, I never would have said that. I would have fought for that idea tooth and nail. How dare anybody violate my constitutional rights and blah, blah, blah. But, I'm sorry! So your privacy is invaded? Once or twice. Big deal. You want to talk about invaded privacy? You should have reporters call you, wanting to know about your husband.

"So, tell me, was he an addict?"...

"So, tell me, did he steal drugs from the hospital?"

That's invaded privacy!

CPHP: Does this interview feel a little like the same thing?
Beth: No, not at all. First of all, we're doing this for a reason. There's a purpose for this. And second, all they wanted was the dirt. They didn't know, or care about, where we met, that we went to the high school prom together. That we were high school sweethearts. That Rick was straight-A in college, and Phi Beta Kappa. All they wanted to know was, "Were the allegations true that he stole drugs?" All they wanted was the dirt. They didn't want to know that he was a wonderful daddy. And that he loved his children. And that he did a lot of good in his life, and helped a lot of people even in the short time that he was a doctor. They only wanted to know the negative part.

But, no matter how he died, it had no effect on the good he did. Or the good person he really was. In spite of everything, I have no regrets. If I'd have known twelve years ago that we would only have twelve years, I'd have done the same thing. In a heartbeat.

This article is reprinted with permission from the Colorado Physician Health Program Newsletter. We are grateful to Beth Sims for the gift of sharing her experience. If you can identify with Beth's story, and are worried about yourself or someone you care about, call the Arkansas Physicians' Health Committee. Don't throw your profession away because of drugs and/or alcohol. Contact the confidential assistance hotline at (501) 370-8221. ■

TAKE THE FIRST STEP TO RECOVERY

The Physicians' Health Committee exists for you!

The Committee is composed primarily of physicians who have been there" and want to help their colleagues from making a mistake.

ON CALL FOR YOU

Don't throw your profession away because of drugs and/or alcohol. Contact our Physicians' Confidential Assistance Hotline at:

(501) 370-8221

All inquiries are confidential.

Arkansas HIV/AIDS Report 1983-1992

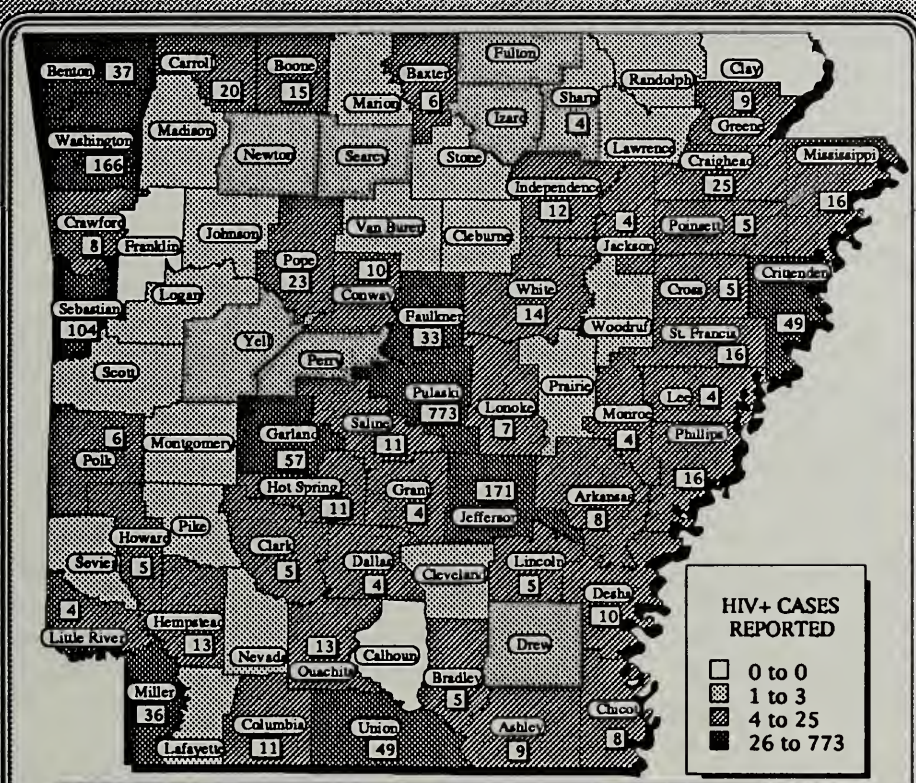
Arkansas: June 1983 through June 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	438	420	184	1,609	85.54
	Female	1	1	6	27	39	71	90	37	272	14.46
AGE	< 5	0	0	1	1	2	9	14	4	31	1.65
	5-12	0	0	0	1	1	5	2	0	9	0.48
	13-19	0	0	0	8	8	14	20	16	66	3.51
	20-29	8	10	15	109	124	192	152	87	697	37.05
	30-39	7	15	22	86	105	206	217	79	737	39.18
	40-49	4	7	11	24	35	61	72	24	238	12.65
	> 49	1	1	6	6	12	19	23	11	79	4.20
	Unknown	0	0	0	8	3	3	10	0	24	1.28
RACE	White	16	24	47	171	178	353	310	131	1,230	65.39
	Black	4	9	8	70	107	152	195	86	631	33.55
	Other	0	0	0	2	5	4	5	4	20	1.06
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	221	1,881	100%

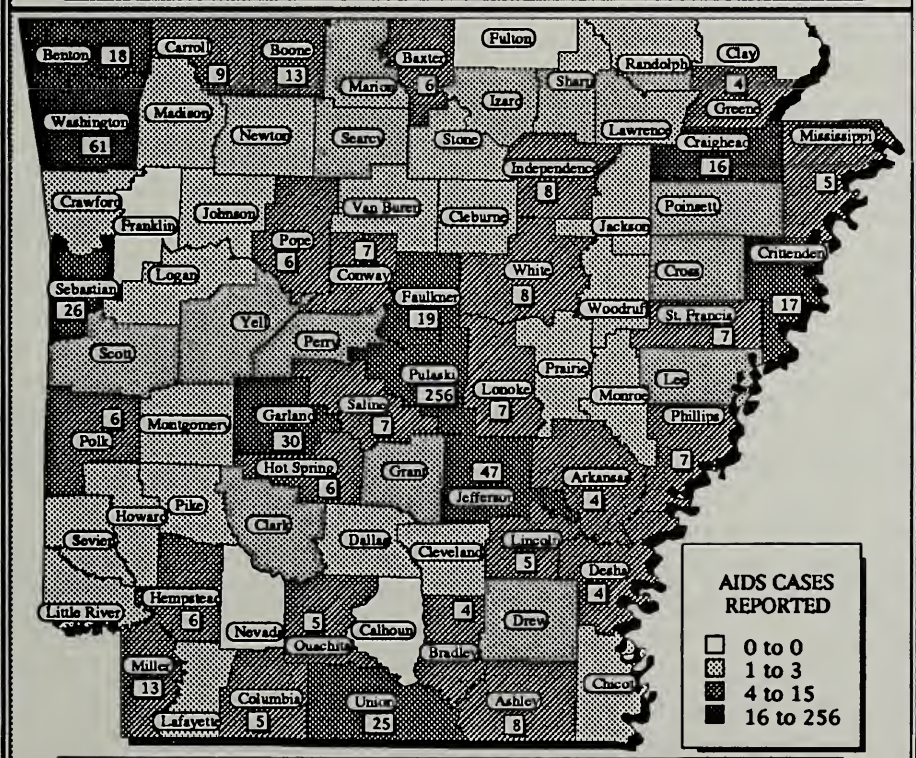
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	90	668	89.54
	Female	1	0	4	6	10	20	25	12	78	10.46
AGE	< 5	0	0	0	1	1	6	6	1	15	2.01
	5-12	0	0	0	1	0	1	1	0	3	0.40
	13-19	0	0	0	0	0	4	3	1	8	1.07
	20-29	7	9	15	27	24	55	57	31	225	30.16
	30-39	3	13	23	36	41	78	80	40	314	42.09
	40-49	1	6	8	10	7	35	41	19	127	17.02
	> 49	1	0	4	8	7	11	13	10	54	7.24
RACE	White	9	22	43	61	58	141	134	69	537	71.98
	Black	3	6	7	20	21	47	66	31	201	26.94
	Other	0	0	0	2	1	2	1	2	8	1.07
RISK	Male/Male Sex	7	17	31	59	50	118	118	58	458	61.39
	Injection Drug User (IDU)	0	2	10	4	11	18	28	14	87	11.66
	Male/Male Sex & IDU	3	9	4	6	6	18	17	6	69	9.25
	Heterosexual	2	0	2	3	6	10	10	8	41	5.50
	Transfusion	0	0	2	7	3	7	11	2	32	4.29
	Perinatal	0	0	0	1	1	6	6	1	15	2.01
	Hemophiliac	0	0	0	1	1	5	5	2	14	1.88
	Undetermined	0	0	1	2	2	8	6	11	30	4.02
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	102	746	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 1,881 Arkansans have been reported to be HIV+ as of June 25, 1992.



A total of 746 Arkansans have been diagnosed with AIDS as of June 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

ARKADELPHIA

Ford, Michael R., Family Practice. Born, 12/7/55. Medical education, UAMS, 19982. Internship/residency, Naval Hospital, Pensacola, FL, 1985. Board certified.

CLARKSVILLE

Burch, Mary J., Family Practice. Born, 2/16/62. Medical education, UAMS, 1989. Internship/residency, AHEC, Fort Smith, 1992. Board eligible.

CONWAY

Jones, Shelley A., Internal Medicine. Born, 12/4/60. Medical education, University of Iowa, Iowa City, 1986. Internship/residency, Iowa Methodist Medical Center, Des Moines, 1989. Board certified.

FAYETTEVILLE

Mauro, Kirk T., Physical Medicine & Rehabilitation. Born, 6/2/61. Medical education, University of Pittsburgh, 1988. Internship/residency, St. Francis Medical Center, 1992. Board certified.

FORT SMITH

Henson, Clinton H., OB/GYN. Born, 2/27/61. Medical education, UAMS, 1987. Internship/residency, Pitt County Memorial, Greenville, NC, 1992.

LITTLE ROCK

Andersen, Bruce J., Neurosurgery. Born, 7/15/56. Medical education, Northwestern University, Chicago, IL, 1982. Internship, Medical College of Virginia, 1983. Residency, Oregon Health Sciences University, 1991.

Bardales, Ricardo H., Pathology-Cytopathology. Born, 10/21/50. Medical education, San Marcos University, Lima, Peru, 1978. Internship, Lima, Peru, 1978. Residency, Montefiore Medical Center, Bronx, NY, 1990. Board certified.

Bonner, Cynthia M., Pediatrics. Born, 6/19/63. Medical education, University of Alabama, Birmingham, 1989. Internship/residency, ACH/UAMS, 1990. Pending certification.

Crittendon-Meadors, Carol, Anesthesiology. Born, 4/13/54. Medical education, Baylor College of Medicine, Houston, TX, 1985. Internship/residency, Baylor College of Medicine, Houston, TX, 1989. Board certified.

Lam, Byron L., Neuro-Ophthalmology. Born, 1/22/62. Medical education, Boston University, MA, 1986. Internship/residency, Swedish Covenant Hospital, Chicago, IL, 1987; University of Iowa Hospitals & Clinics, Iowa City, IA, 1990. Board certified.

Lea, Allen K., Family Medicine. Born, 3/23/57. Medical education, UAMS, 1984. Internship/residency, UAMS, 1992.

Schutz, Michael J., Urology. Born, 11/16/60. Medical education, University of Medicine and Dentistry, Newark, New Jersey, 1985. Internship/residency, University of Medicine and Dentistry, Newark, New Jersey, 1987.

Stine, Kimo C., Pediatrics. Born, 12/6/52. Medical education, University of Kansas, Kansas City, 1982. Internship/residency, University of Kansas, Kansas City, 1985. Board certified.

Stokes, Bernard D., Gastroenterology. Born, 2/12/58. Medical education, UAMS, 1984. Internship/residency, University of Tennessee for Health Sciences, Memphis, 1987. Fellowship, University of Kentucky, Lexington. Board certified.

MARKED TREE

Price, Joel A., General Practice. Born, 9/17/52. Medical education, UAMS, 1978. Internship/residency, AHEC-Northwest, Fayetteville, 1980.

MENA

Brown, David P., General Practice. Born, 5/16/53. Medical education, Universidad Technologica de Santiago, Dominican Republic, 1987. Internship/residency, AHEC-South, 1991.

MOUNTAIN HOME

Hollis, Roland D., Family Practice. Born, 8/17/61. Medical education, UAMS, 1989. Internship/residency, Jefferson Regional Medical Center, Pine Bluff, 1992. Board eligible.

Yoder, Robert R., Psychiatry. Born, 4/21/22. Medical education, University of Michigan, Ann Arbor, 1946. Internship/residency, University of Michigan, 1951. Board certified.

PINE BLUFF

Bruton, J. Lewis, Internal Medicine/Nephrology. Born, 3/29/59. Medical education, UAMS, 1985.

Internship/residency, UAB, 1988. Fellowship, University of Texas Health Science Center, San Antonio, 1990. Board certified.

ROGERS

Day, Geoffrey A., Radiology. Born, 4/30/61. Medical education, Oklahoma University College of Medicine, Oklahoma City, 1988. Internship/residency, University of Oklahoma Health Sciences Center, 1992.

ROLAND

Hutchison, George R., Emergency Medicine. Born, 7/17/53. Medical education, Southwestern Medical School, Dallas, 1986. Internship/residency, 1991.

TEXARKANA

House, Roger D., Psychiatry/Family Practice. Born, 3/6/50. Medical education, UAMS, 1977. Residency, AHEC, Pine Bluff, 1980. Board certified, Family Practice. Board eligible, Psychiatry.

OUT-OF-STATE

Hardy III, Dwight, General Practice, Tulsa, OK. Born, 8/3/53. Medical education, Oklahoma School of Osteopathic Medicine & Surgery, Tulsa, 1981. Internship, Tulsa Regional Medical Center, OK, 1982. Board eligible.

RESIDENT PHYSICIAN SECTION

Beasley, Darryl K., Anesthesiology. Born, 12/13/56. Medical education, UAMS, 1992. Internship, University of Illinois, Chicago.

Benanti, Jan Marie, Obstetrics. Born, 1/6/56. Medical education, Louisiana State University School of Medicine, New Orleans, 1987. Internship/residency, LSU Affiliated Hospitals, New Orleans. Fellowship, UAMS.

Bevans III, David, General Surgery. Born, 2/26/66. Medical education, UAMS, 1992. Residency, UAMS.

Bruffett, Wayne, Orthopaedic Surgery. Born, 8/13/65. Medical education, Baylor College of Medicine, Houston, TX, 1992. Internship/residency, UAMS.

Cathcart, Evelyn. Born, 10/4/65. Medical education, UAMS, 1992.

Chance, Robert. Born, 2/13/62. Medical education, University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1991. Internship, Still Regional Medical Center, Jefferson City, MO. Residency, UAMS.

Chu, Melissa, Family Practice. Born, 08/26/64. Medical education, UAMS, 1992.

Clay, David, Internal Medicine. Born, 9/12/63. Medical education, UAMS, 1992. Internship/residency, UAMS.

Cochran, Melvin. Born, 5/22/58. Medical education, University of Texas Medical School, San Antonio, 1992.

Coffman, John L. Born, 9/25/65. Medical education, UAMS, 1992. Internship, UAMS.

Cole, Andrew A., OB/GYN. Born, 11/24/65. Medical education, UAMS, 1992. Internship, UAMS.

Coleman, Ryan B. Born, 2/22/66. Medical education, UAMS, 1992.

Craig, Jeffrey A., Pediatrics. Born, 11/22/61. Medical education, UAMS, 1992. Internship, UAMS/Arkansas Children's Hospital.

Davis, Scott A., Internal Medicine. Born, 11/14/64. Medical education, UAMS, 1992. Internship, UAMS.

Edattukaren, Varghese, Family Practice. Born, 2/3/46. Medical education, T.D. Medical College, Kerala University, Alleppey, India, 1971. Internship, T.D. Medical College, Kerala University, Alleppey, India. Residency, University of Oklahoma, Tulsa and AHEC, Fort Smith.

Ehret, Roger, OB/GYN. Born, 8/15/62. Medical education, Tulane University School of Medicine, New Orleans, LA, 1992. Internship/residency, UAMS.

Ehret, Rose, Pediatrics. Born, 6/26/66. Medical education, Tulane University School of Medicine, New Orleans, LA, 1992. Residency, UAMS.

Ellis, Dean R., Ophthalmology. Born, 8/3/66. Medical education, University of Missouri, Columbia, 1992. Internship, UAMS. Residency, University of North Carolina, Chapel Hill.

Ellis, Mark R., Pediatrics. Born, 6/30/63. Medical education, UAMS, 1992. Internship, UAMS.

Fahlberg, Laura, Psychiatry. Born, 8/11/65. Medical education, Texas A&M University College of Medicine, College Station, 1992. Internship, UAMS.

Fegan, Jeff, Urology. Born, 6/6/57. Medical education, Baylor College of Medicine, Houston, TX, 1988. Internship, Baylor College of Medicine, Dallas. Residency, Baylor College of Medicine, Dallas, and UAMS. Fellowship, University of Texas Southwestern Medical Center, Dallas.

Hall, Scott M., . Born, 2/15/67. Medical education, UAMS, 1992. Internship, AHEC-NE, Jonesboro.

Harris, Patricia, Pediatrics. Born, 10/22/59. Medical education, University of Alabama School of Medicine, Birmingham, 1992. Internship, UAMS.

Horan, Mark, Family Practice. Born, 4/13/65. Medical education, University of Texas Medical School, Houston, 1992. Internship/residency, AHEC, Fort Smith.

Horan, Michelle, Family Practice. Born, 10/16/

66. Medical education, University of Texas Medical School, Houston, 1992. Internship, AHEC, Fort Smith.

Ick, Kurt. Born, 6/3/66. Medical education, University of Kansas Medical Center, School of Medicine, Kansas City, 1992.

Jeffries, Robert, Ophthalmology. Born, 1/30/63. Medical education, UAMS, 1992. Internship, UAMS.

Jones, Olcay. Born, 1/1/59. Medical education, Haceteppe University, Faculty of Medicine, Ankara, Turkey, 1982.

Jones, Steven, Anesthesiology. Born, 6/14/66. Medical education, UAMS, 1992. Internship, UAMS.

Keplinger, Florian, Physical Medicine & Rehabilitation. Born, 7/31/57. Medical education, Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines, 1982. Internship, Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines. Residency, UAMS.

Kibodeaux, Jacquelyn. Born, 1/21/66. Medical education, Louisiana State University School of Medicine, Shreveport, 1992.

Kim, Nam H., Internal Medicine. Born, 2/20/62. Medical education, University of Texas Health Sciences, San Antonio, 1988. Internship/residency, University of New Mexico Hospital, Albuquerque.

Kirchner, JoAnn E., Psychiatry. Born, 10/27/58. Medical education, UAMS, 1992.

Kiser, Pamela. Born, 10/28/60. Medical education, University of Missouri School of Medicine, Columbia, 1992.

Klasner, Ann, Pediatrics. Born, 12/18/65. Medical education, University of Illinois College of Medicine, Chicago, 1992. Residency, UAMS.

Kuhn, Ronald G., Urology. Born, 5/14/65. Medical education, UAMS, 1991. Internship, UAMS.

Lansford, Bryan, General Surgery. Born, 2/23/63. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1990. Internship/residency, University of Tennessee.

LaPietra Jr., Jesse, Radiology. Born, 6/11/66. Medical education, Tulane University School of Medicine, New Orleans, LA, 1992. Residency, UAMS.

Lefler, Mark, Family Practice. Born, 7/16/66. Medical education, UAMS, 1992.

Levine, Jeffrey, Gastroenterology. Born, 5/11/62. Medical education, State University of New York Health Science Center, Syracuse, 1987. Internship/residency, Medical College of Pennsylvania. Fellowship, UAMS.

Libuit, Noel, Clinical Pathology. Born, 2/7/61. Medical education, University of Texas Medical School, Houston, 1990. Internship, Mt. Zion of UCSF, San Francisco, CA. Residency, UAMS.

Malik, Salman, Cardiology. Born, 5/23/62. King Edward Medical College, University of Punjab, Lahore, West Pakistan, 1985. Internship, Nassau County Medical Center, Meadow, NY. Residency, University of Utah Medical Center, Salt Lake City. Fellowship, UAMS.

Marotti, A. Scott, General Surgery. Born, 12/12/62. Medical education, UAMS, 1992. Internship, UAMS.

Mays, Kevin P., Psychology. Born, 1/19/67. Medical education, University of Kansas Medical Center, School of Medicine, Kansas City, 1992. Residency, UAMS.

McCann Jr., Ronald, Radiology. Born, 8/30/66. Medical education, St. Louis University School of Medicine, MO, 1992. Residency, UAMS.

McLendon, Kristi, Emergency Medicine. Born, 4/29/60. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1992. Internship, UAMS.

Montgomery, Sarah, OB/GYN. Born, 7/23/64. Medical education, Cornell University Medical College, New York, 1990. Internship, University of Colorado Medical Sciences, Denver. Residency, UAMS.

Mosher, Lisa, Pediatrics. Born, 5/31/66. Medical education, University of Tennessee College of Medicine, Memphis, 1992.

North, Paula, Pathology. Born, 7/31/52. Medical education, UAMS, 1992. Residency, UAMS.

Payne, Richard. Born, 3/20/66. Medical education, UAMS, 1992. Internship, UAMS.

Pirich, Laura, Pediatrics. Born, 2/3/65. Medical education, UAMS, 1992. Internship, UAMS.

Rettele, Garrick A., Ophthalmology. Born, 5/15/65. Medical education, University of Kansas Medical Center, Kansas City, 1991. Internship, University of Kansas Medical Center. Residency, UAMS.

Robinson, Matthew M., Urology. Born, 9/3/64. Medical education, University of Texas School of Medicine, San Antonio, 1990. Internship, UAMS. Residency, UAMS and University of Texas Health Science Center, San Antonio.

Rogers, Marc A. Born, 2/11/66. Medical education, UAMS, 1992. Internship, UAMS.

Roser, Steven, Orthopaedic Surgery. Born, 5/5/66. Medical education, Vanderbilt University School of Medicine, Nashville, TN, 1992. Internship, UAMS.

Scruggs, Tonya, Pediatrics. Born, 6/9/66. Medical education, UAMS, 1992. Internship, UAMS.

Shaver, Robert, Pathology. Born, 5/18/64. Medical education, UAMS, 1992. Internship, UAMS.

Slaven, John, Anesthesiology. Born, 11/15/63. Medical education, UAMS, 1991. Internship, Kaiser Permanente Hospital, Oakland, CA. Residency, UAMS.

Sparling, Ed, Orthopaedic Surgery. Born, 11/24/56. Medical education, University of California School of Medicine, Davis, 1992. Internship/resi-

dency, UAMS.

St. Pierre, Mark A., Internal Medicine. Born, 1/1/62. Medical education, UAMS, 1992. Internship, UAMS.

Stepp, Robert. Born, 8/27/60. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1992.

Stills, David A. Born, 4/22/65. Medical education, UAMS, 1992.

Stowart III, Jimmie. Born, 4/13/65. Medical education, UAMS, 1992. Internship, UAMS.

Tharp, John G., Psychology. Born, 8/28/57. Medical education, University of Texas Southwestern Medical School, Dallas, 1989. Internship/residency, University of Texas Southwestern Medical School. Fellowship, UAMS/ACH.

Thomas Jr., Donald, Radiology. Born, 4/21/66. Medical education, Louisiana State University School of Medicine, Shreveport, 1992.

U, Tha, Neurology. Born, 12/14/62. Medical education, Institute of Medicine I, Rangoon, Burma, 1987. Internship/residency, UAMS.

Vitti, Michael J., General Surgery. Born, 9/24/60. Medical education, New York University School of Medicine, 1986. Internship/residency, St. Luke's - Roosevelt Hospital, New York, NY.

Wilson, Matthew. Born, 2/3/65. Medical education, UAMS, 1991. Internship, Hospital St. Raphael, New Haven, CT.

Woodson, Alexa, Family Practice. Born, 12/26/61. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1992. Internship/residency, AHEC, Fort Smith.

Woodson, Mark. Born, 10/30/61. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1992.

MEDICAL STUDENTS

Botwinick, Dawn M.
Ford, Barry G.
Hays, David A.
McAlister-Fusco, Tamara L.
Minden, Sharon E.
Plumley Jr., Spencer
Taylor, Toby A.
Walter, Matthew T.

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicains who have completed acceptable programs of continuing education. The recipients for the months of April, May, and June are:

John D. Ashley	Newport
Omar T. Atiq	Fort Smith
Samuel W. Boellner	Little Rock
Jimmy D. Bonner	Paragould
Michael S. Bouton	Fort Smith
Charles M. Boyd	Little Rock
R. Frederick Broach	Little Rock
James L. Builteman	Fort Smith
Deland D. Burks	Fort Smith
Dan P. Chisholm	Little Rock
Lisa A. Cosgrove	Little Rock
Richard E. Daily	Van Buren
James P. DeRossitt	Forrest City
Robert W. Donnell	Rogers
Noel F. Ferguson	Harrison
Ernest J. Ferris	Little Rock
Paul M. Fiser	Little Rock
F. Perry Franz	Fort Smith
David C. Garrett	Rogers
Roger L. Green	Newport
Richard L. Hardcastle	Paragould
Curtis L. Hedberg	Springdale
Richard D. Jennings	Jonesboro
Jerry R. Kendall	Camden
Patricia A. Knott	Sherwood
Thomas W. Koonce	Little Rock
Alice R. Laule	Harrison
Charles W. Logan	Little Rock
Albert Dutton W. MacDade	Fort Smith
Alice M. Martinson	Berryville
Emma J. Mauch	Russellville
David A. Miles	Little Rock
Elsey L. Milner	Little Rock
Michael N. Moody	Salem
Joseph S. Murphy	Little Rock
Joseph A. Norton	Little Rock
Merlyn B. Page	Mena
Robert L. Parkman	Magnolia
Donald H. Pennington	Clarksville
Curtis B. Pickert	Little Rock
Carl M. Riddell	Russellville
William H. Riley	Little Rock
Rickey O. Ryals	Jonesboro
John E. Slayden	Little Rock
Sergio F. Soto-Figueroa	Russellville
Terri Y. Schweitzer	Jonesboro
Sebastian A. Spades	Walnut Ridge
Robert M. Stainton	Jonesboro
Philip B. Tippin	Ola
Douglas A. Treptow	Rogers
Don B. Vollman	Jonesboro
Roy T. Webb	Hot Springs
Samuel B. Welch	Little Rock
Raymond A. Wende	Little Rock
Edwin Whiteside	Fort Smith
Joseph T. Wilson	Jonesboro

AMS Newsmakers

Dr. H.A. Bailey Jr., president of the Ear Nose and Throat Clinic in Little Rock, was honored by the board of directors of the Visiting Nurse Association of Arkansas for outstanding contribution to the community by providing health-care needs to Little Rock area residents.

Dr. Claudia Davis, a geriatric specialist at the Little Rock Diagnostic Clinic, was named Physician of the Year by the Arkansas Association of Home Health Agencies. The award is given to recognize physicians who have excelled in the promotion and utilization of homecare services.

Dr. James Headstream, a retired Little Rock urologist, was honored by the board of directors of the Visiting Nurse Association of Arkansas for outstanding contribution to the community by providing health-care needs to Little Rock area residents.

Dr. Thomas C. Jefferson, a pediatrician with the Holt-Krock Clinic in Fort Smith, has been appointed medical director of the children and adolescent rehabilitation program at Fort Smith Rehabilitation Hospital.

Dr. Charles R. Klepper, and internist from Harrison, has been elected a Fellow of the Royal Society of Medicine, London, England.

Dr. Betty Lowe, medical director for Arkansas Children's Hospital and professor of pediatrics for the university of Arkansas for Medical Sciences, has been named vice president-elect of the American Academy of Pediatrics.

Dr. Mike McFarland, of McFarland Eye Surgery Center of Pine Bluff, has received the "1992 Innovator's Award" for the development of sutureless cataract surgery and the "1992 Hot Shot Phaco Surgeon Award" for using the most outstanding surgical technique from the Irish American Ophthalmological Society.

Dr. Lee Parker, director of AHEC-Northwest in Fayetteville, was awarded a Distinguished Service Award by the University of Arkansas for Medical Sciences College of Medicine. The award cited Dr. Parker for hiss "exemplary contribution to the development of the educational, research and public service programs of the college."

Dr. Ben Saltzman, a retired public health physician from Mountain Home, has been elected to the board of directors of CARTI in Mountain Home.

Dr. R. Bruce White, an oncologist from Mountain Home, has been elected to the board of directors of CARTI Mountain Home.

Mr. Lynn Zeno

Congratulations Lynn!

Z. Lynn Zeno, director of Governmental Affairs for the Arkansas Medical Society, was the recipient of the Ken Graves Memorial Award for Association Excellence, at the summer meeting of the Arkansas Society of Association Executives (ASAE) in Eureka Springs.

The award is the most prestigious honor awarded by ASAE to an association executive who has exemplified an exceptional level of professionalism in association management and in their community.

Lynn currently serves as one of ten members of the American Medical Association's Legislative Advisory Council and is the immediate past president of the Arkansas Professional Lobbyist Association.

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In Memoriam

Carl T. Beck, M.D.

Dr. Carl Thomas Beck, a family physician from Mountain View, died Friday, July 10, 1992. He was 57.

Dr. Beck was a member of the American Medical Association, the Arkansas Medical Society, and the Independence County Medical Society.

Survivors are his wife, Sherri June Beck; three sons, Scott Beck, of Schreiver, La., Kirk Beck of Cocoa Beach, Fla., and Andy Beck of Mountain View; a daughter, Kim Snowden of Marion; his father, Bill Beck of Prescott; and two brothers, Jerry Beck and Gary Beck, both of Prescott.

Edgar J. Easley, M.D.

Dr. Edgar Jesse Easley, a retired assistant state health officer from Little Rock, died Saturday, May 30, 1992. He was 87.

Dr. Easley was a life member of the Arkansas Medical Society, and a member of the American Medical Association and the Pulaski County Medical Society.

Survivors are his wife, Norma Dunlap Easley; a son, Edgar D. Easley of North Little Rock; a sister, Mrs. Ethel E. Hawkins of Little Rock; six grandchildren; and four great-grandchildren.

Elizabeth C. Fields, M.D.

Dr. Elizabeth C. Fields, a general practice physician from Jackson, Tenn., died Friday, May 29, 1992. She was 66.

Dr. Fields was a member of the Arkansas Medical Society.

Dr. Fields is survived by two sons, Dan Nowell of Jackson, Tenn., and William D. Fields Jr. of Jonesboro; five daughters, Lynda Harris and Elizabeth Leisure, both of Marianna, Nelda and Libby Strunk, both of Kokomo, Ind., and Faith Vanover of Lexington, Ky.; and 16 grandchildren.

James Growdon, M.D.

Dr. James Growdon, former professor and chairman of the department of surgery at the University of Arkansas School of Medicine, died Sunday, June 28, 1992. He was 76.

Dr. Growdon was an emeritus member of the Arkansas Medical Society and a member of the Pulaski County Medical Society.

Dr. Growdon is survived by his wife, Louise Smith Growdon; two sons, Dr. James H. Growdon Jr. of Brentwood, Tenn., and Dr. William A. Growdon of Pacific Palisades, Calif.; a daughter, Mrs. Mary Lou Peterson of Ailey, Ga.; a brother, Dr. John A. Growdon of Shawnee Mission, Kan.; and six grandchildren.

Anthony C. Hooper, M.D.

Dr. Anthony Clay Hooper, of Ballwin, Mo., formerly of Jonesboro, died Friday, July 3, 1992. He was 47.

Dr. Hooper is survived by a son, Matthew Hooper of Hot Springs; a daughter, Meredith Hooper of Hot Springs; his mother, Mrs. Elaine Hooper of Jonesboro; and two sisters, Mrs. Betty Phillips of LaGuna Niguel, Calif., and Mrs. Sara Metzger of Albuquerque, New Mexico.

Robert R. Matthews, M.D.

Dr. Robert R. Matthews, a psychiatrist for the Arkansas State Hospital in Little Rock, died Thursday, July 9, 1992. He was 62.

Dr. Matthews was a member of the American Medical Association, the Arkansas Medical Society, and the Pulaski County Medical Society.

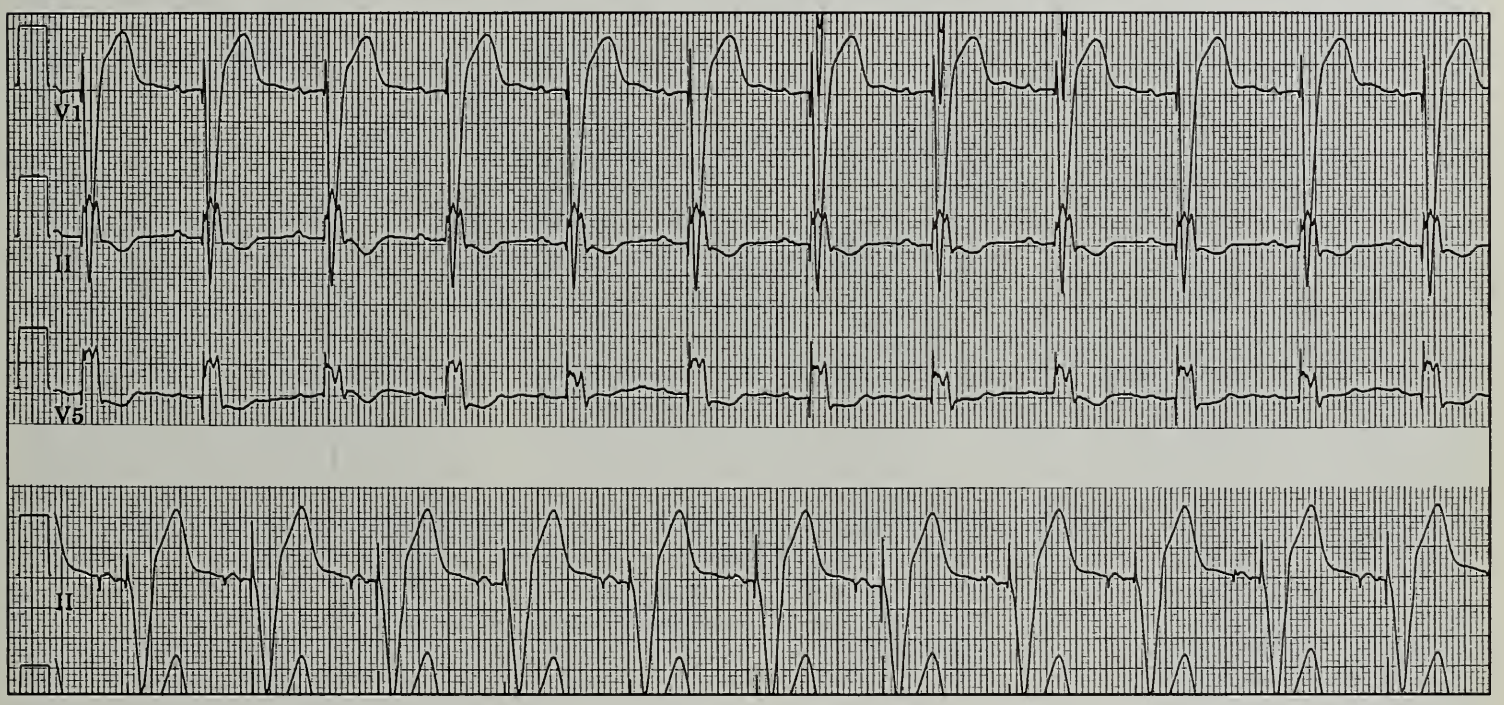
Survivors are his wife, Barbara Joan Boyd Matthews; three sons, Boyd Matthews of Indian Springs, Nev., Brett Matthews of Baton Rouge, La., and Robert B. Matthews of Arlington, Va.; a daughter, Marcia Matthews of Austin; and a grandchild.

Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

This record was obtained from a 91-year-old man with an artificial pacemaker. What kind is it?



DISCUSSION:

Stimulus artifacts ("pacemaker spikes") precede each QRS complex indicating that the ventricles are being paced. This suggests the patient has a ventricular pacemaker. However, a P wave precedes each stimulus artifact by a fixed interval of 200 msec. This suggests that the pacemaker is sensing atrial activity. If a QRS is not sensed by the ventricular amplifier or sensing circuit within a specified period of time, the ventricular generator is fired. This suggests the presence of a dual chamber unit pacemaker. These days, this is most often a DDD unit, with both atrial and ventricular sensing and pacing. The response to sensed activity can be either inhibited (I), triggered (T) or both (dual, D). In the Lead II rhythm strip obtained four days previously (mounted below the 12 lead ECG) separate stimulus artifacts precede both the P waves and QRS complexes, evidence of both atrial and ventricular pacing. The rate in the lower strip is 70 BPM whereas the rate in the 12-lead is 72 BPM. Thus in the upper record, the sinus rate exceeded the minimal rate of the pacemaker, resulting in inhibition of atrial pacing.

If you compare the QRS morphology in Lead II in the upper and lower readings, you will notice that the QRS morphology differs on the two days. This could mean two things: 1) that the pacemaker lead has moved or has been changed; or 2) the QRS complexes in the 12-lead ECG represent fusion complexes between paced and conducted complexes. The former would be a cause of concern, suggesting that the pacemaker lead might have migrated from its original position. The second mechanism is, however, more likely. When the patient is in sinus rhythm (upper panel), the QRS has a left bundle branch block morphology. Given the relatively long period between the onset of the P wave and the ventricular pacemaker stimulus artifact (200 msec), it is likely that there was sufficient time for the sinus impulse to be conducted. It is not known whether the patient had a pre-existing left bundle branch block. Clinical correlation is required to differentiate between these possibilities.

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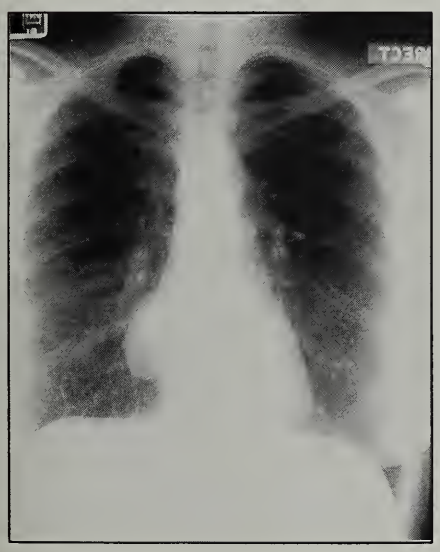
Radiological Case of the Month

Steven R. Nokes, M.D.
Susan W. Baker, M.D.
Sidney P. Hayes, M.D.
John M. Ransom, M.D.

History:

This 38-year-old woman presented with progressive weakness and chest pain.



Figures 1a and 1b. PA and lateral chest.

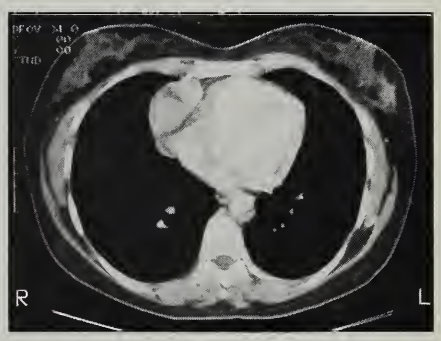


Figure 2. Axial CT scan of the chest with contrast.

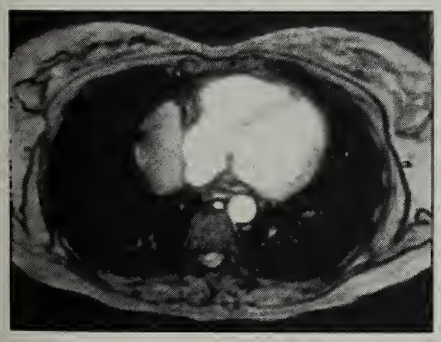
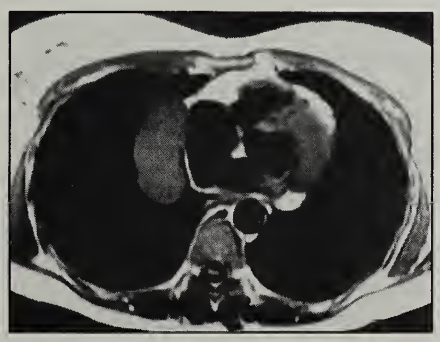
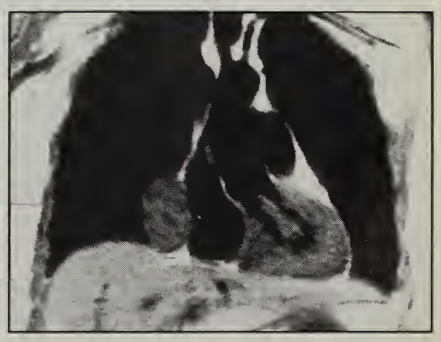


Figure 3. Axial cine MR.





Figures 4a and 4b. Axial and coronal T_1-weighted MR.

Thymoma

Findings:

The PA chest reveals a smooth mass in the right cardiophrenic angle, separated from the diaphragm. The lateral chest localizes the mass to the anterior mediastinum. The CT scan demonstrates a lobular enhancing mass adjacent to the right atrium, without calcification. The MR images show a lobular anterior mediastinal mass with homogeneous signal similar to muscle on T_1 and increased signal on T_2-weighting.

Discussion:

The differential diagnosis on the plain films should include a pericardial cyst, anterior mediastinal mass (thymoma, lymphoma, or teratoma), a cardiac tumor or aneurysm, and possibly a pulmonary neoplasm. The CT excludes a cyst. The MR scan excludes aneurysm as no flow void is present on spin echo imaging and flowing blood is not demonstrated using the cine technique. While thymomas are typically closely related to the root of the aorta and pulmonary artery, they may occur anywhere within the anterior mediastinum, which is defined radiographically by a vertical line extending along the posterior border of the heart and anterior margin of the trachea.

Thymomas affect men and women with equal frequency and generally occur in patients in the fifth and sixth decades. Half of thymomas are discovered incidentally on radiographs obtained for other reasons. In one quarter of cases, patients present with signs and symptoms related to compression of adjacent mediastinal structures. Compression of the right atrium may occur, causing sudden cardiac death.

Parathymic syndromes occur in 40% of patients with thymoma. These include myasthenia gravis, pure red cell aplasia, hypogammaglobulinemia, as well as endocrine, cutaneous and connective tissue disorders. Primary malignant neoplasms have been described in association with thymomas. Ninety percent of patients with myasthenia gravis will have a thymic abnormality, usually hyperplasia. Approximately 35% of patients with thymoma will have myasthenia gravis.

Approximately 10-15% of thymomas are classified as "malignant." The presence of neoplastic growth through the tumor capsule determines whether the tumor is malignant (invasive). Encapsulated tumors that are completely excised have 93% five-year survival. Invasive thymomas are potentially aggressive and five-year survival ranges from 45-85%. Adjuvant radiation therapy is often effective in local control of the disease.

References

1. Rosado-de-Christenson ML, Galobards J, Moran CE. Thymoma: Radiologic-pathologic correlation. Radiographics, 1992; 12:151-168.

2. Molina PL, Siegel MJ, Glazer HS. Thymic masses on MR imaging. AJR, 1990; 155:495-500.

3. Sakai F, Sone S, Kiyono K, et al. MR imaging of thymoma: radiologic-pathologic correlation. AJR, 1992; 158:751-756.

Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.

Contributor: Susan W. Baker, M.D. is a private practice internist in Little Rock.

Contributor: Sidney P. Hayes, M.D., is affiliated with the Little Rock Pulmonary Clinic.

Contributor: John M. Ransom, M.D., is affiliated with Cardiovascular and Thoracic Surgery Associates in Little Rock.

"Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin, Member, American Medical Association

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"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

You are invited to join Dr. Fullin and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

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Medicine in the News

Health Care Access Foundation Update

As of June 1992, the Arkansas Health Care Access Foundation has provided free medical services to 4,273 medically indigent persons.

The program has 1,505 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

SSF Establishes Helpline

The Short Stature Foundation (SSF) was founded in 1984 as a public, non-profit, tax exempt organization in response to the suicide of 17-year-old Michelle Crandall, a dwarf. Her suicide note stated, "I cannot handle the life God gave me as a short statured person." The acute problems faced by the 2 million short statured/dwarfed people in the United States are often emotionally and physically overwhelming. Many feel socially isolated. Environmental systems are not designed to accommodate them.

The Short Stature Foundation has established a National 1-800-24 DWARF Helpline System, which allows short statured/dwarfed people and their families to contact medical specialists, support groups and other needed services.

Over 90% of the short statured/dwarfed babies born each year are born from average sized parents. Therefore, it is services, information and advocacy to enhance the positive well being and independence of short statured dwarfed individuals and their families.

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Topics in Search of Authors

You can influence your peers - and give something back to your profession - if you plan to write an article for *The Journal of the Arkansas Medical Society*.

The Journal needs your thoughts and ideas. So why not consider putting your expertise on paper? Here are some of *The Journal*'s topics in search of an author.

- Practice management for today's physicians
- Coping with difficult patients
- Women's health issues
- Teens and drug use
- Medicare/Medicaid issues
- Medical ethics and health care
- What's the value of organized medicine?
- New treatments and technology
- Cutting the belt on health-care costs
- Medical history of Arkansas
- A smokeless society
- A doctor's hobby
- Medicine of the future
- Waste management update
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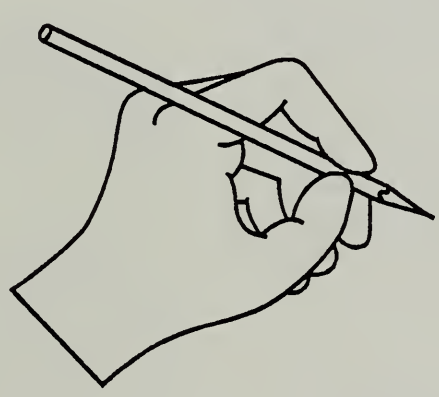

For more details, call or write:
Stephanie Percefull
Managing Editor
The Journal of the Arkansas Medical Society
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Things To Come

August 23-28

New Advances in Internal Medicine: Clinical Applications. Hyatt Regency, Monterey, CA. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: $480 physicians; $350 others; military discounts available. Category I and AAFP credits available. For more information, call (916) 734-5390.

August 24-28

Neuropsychological Assessment: New Directions. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

Psychoanalytic Theory and the Clinical Interchange. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

August 31-September 4

Leadership in an Era of Change. Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: $395. For more information, call (212) 430-2307.

September 24

Nursing Management Certificate Program. Sponsored by and held at the San Jose State University, Department of Continuing Education. For more information, call (408) 924-2601 or (408) 924-2600.

October 8-9

Depression: Phenomenology, Etiology and Treatment. Sponsored by and held at the Laureate Psychiatric Clinic and Hospital, Tulsa, OK. Fees: $75.00, day; $150.00, conference. For more information, call 1-800-322-5173, ext. 4094.

October 26-29

Primary Care Update. Riviera Hotel and Casino, Las Vegas, NV. Sponsored by Interstate Postgraduate Medical Association of North America. CME Category I credit hours available. Fees: $225.00, registration before October 1; $275.00, registration between October 1-21; $325.00, registration after October 21; $50.00, residents, interns, allied health professionals. For more information, call (608) 257-1401.

October 30

3rd Annual Rush Symposium on Hepatic and Biliary Disease. Sponsored by and held at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL. For more information, call Suzanne Buss at (312) 942-6242.

November 6-8

4th Annual Infectious Disease Review. Crowne Plaza Hotel, Rockville, MD. Sponsored by the Clinical Center of the National Institutes of Health. CME Category I credits available. For more information, call Svetlana Lisanti at 1-800-231-0389.

November 8-12

96th Annual Meeting of the American Academy of Ophthalmology. Dallas Convention Center, TX. For more information, call (415) 561-8500.

November 12-15

Southern Medical Association's 86th Annual Scientific Assembly. Registration information will be forthcoming. For more information, call 1-800-423-4992.

November 20-21

Hyperlipidemia. Sponsored by and held at the Univerrsity of California, Davis, Medical Center, Office of Continuing Medical Education, Sacramento, CA. CME Category I credits available. For more information, call (916) 734-5390.

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Keeping Up

Controversies in Cutaneous Laser Surgery

August 27-30, 8:00 a.m., Aspen, CO. Sponsored by the UAMS College of Medicine. Presented by Drs. Milton Waner, Ken Arndt, Roy Geronemus, Allen Schliftman, and Jay Burns. CME Category I credit available. Fees: $380.00. For more information, call Cindy Reid at 686-5261.

Arkansas Medical Society Fall Meeting

November 22, Excelsior Hotel, Little Rock. Registration information and meeting times will be forthcoming. For more information, call Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC
Medical Grand Rounds, Thursday, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 11:30 a.m., conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided. Category 1 credits available.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D

Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

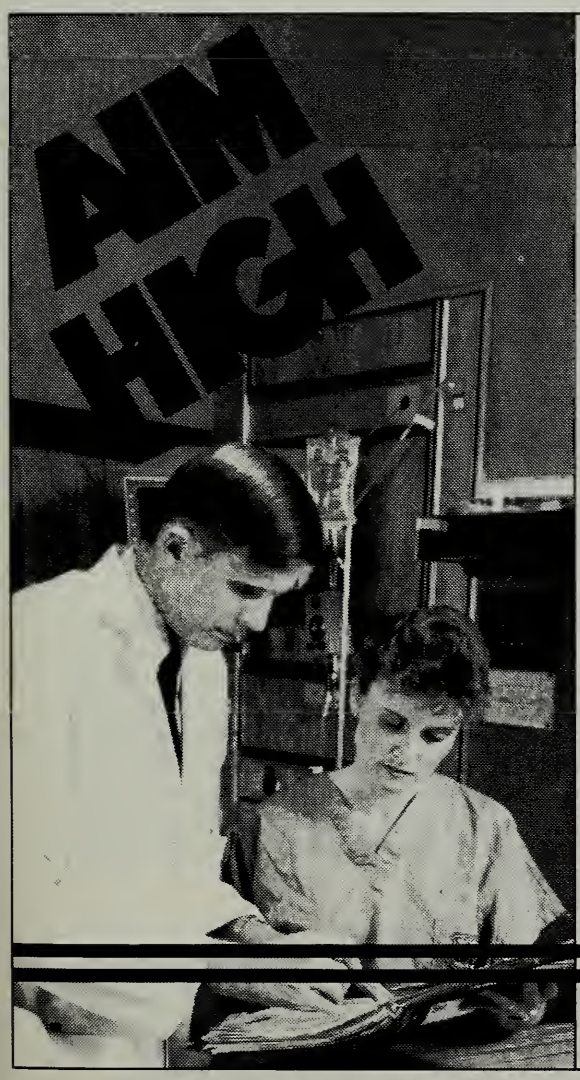
PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center

Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital



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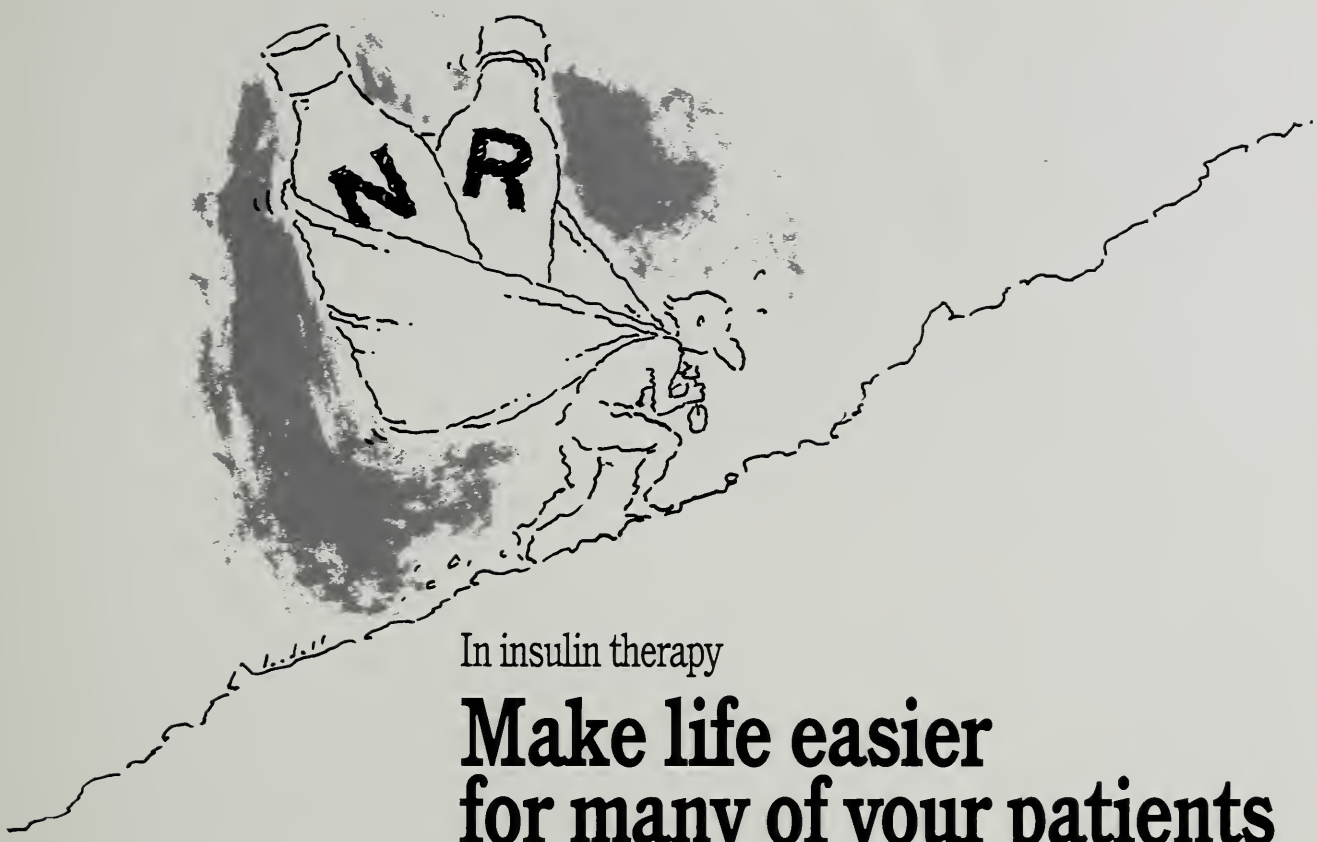

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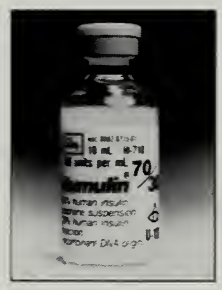

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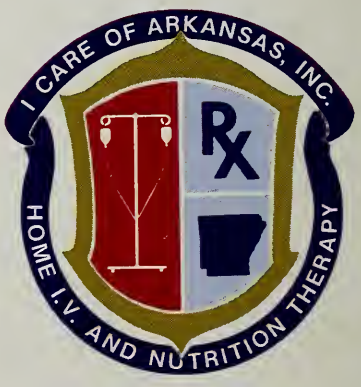

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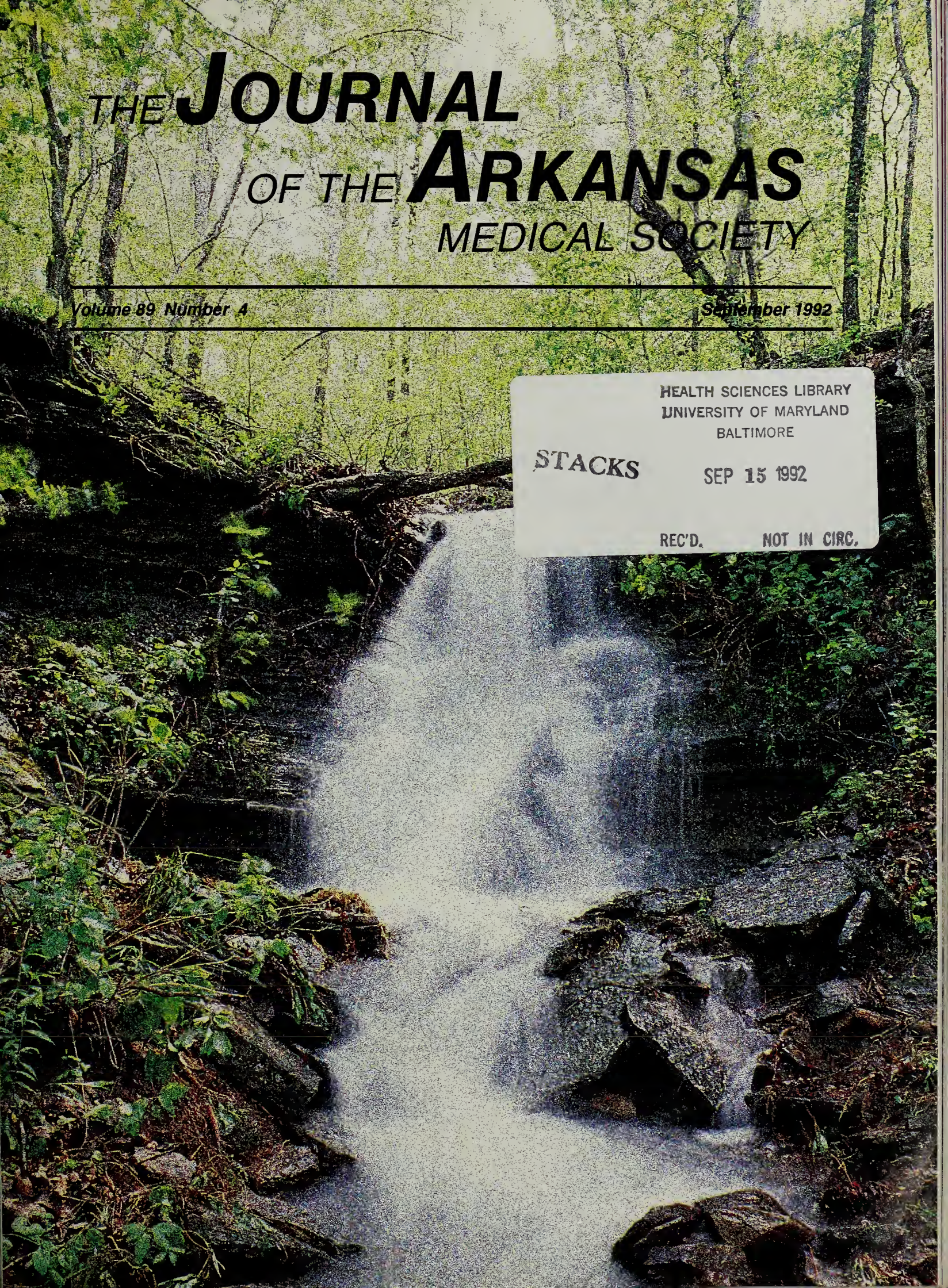

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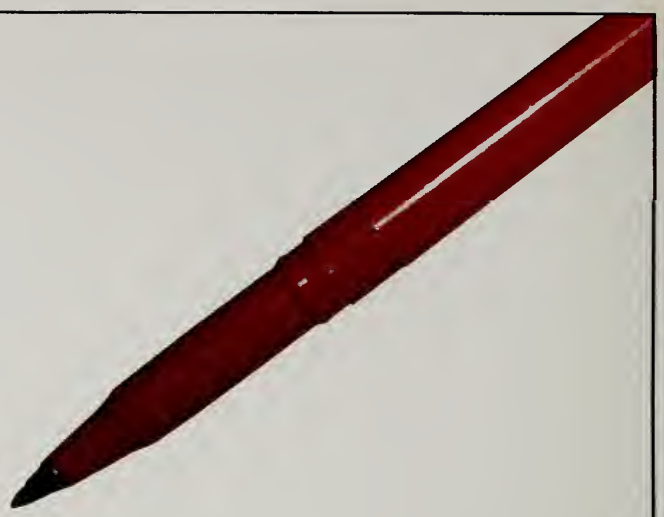

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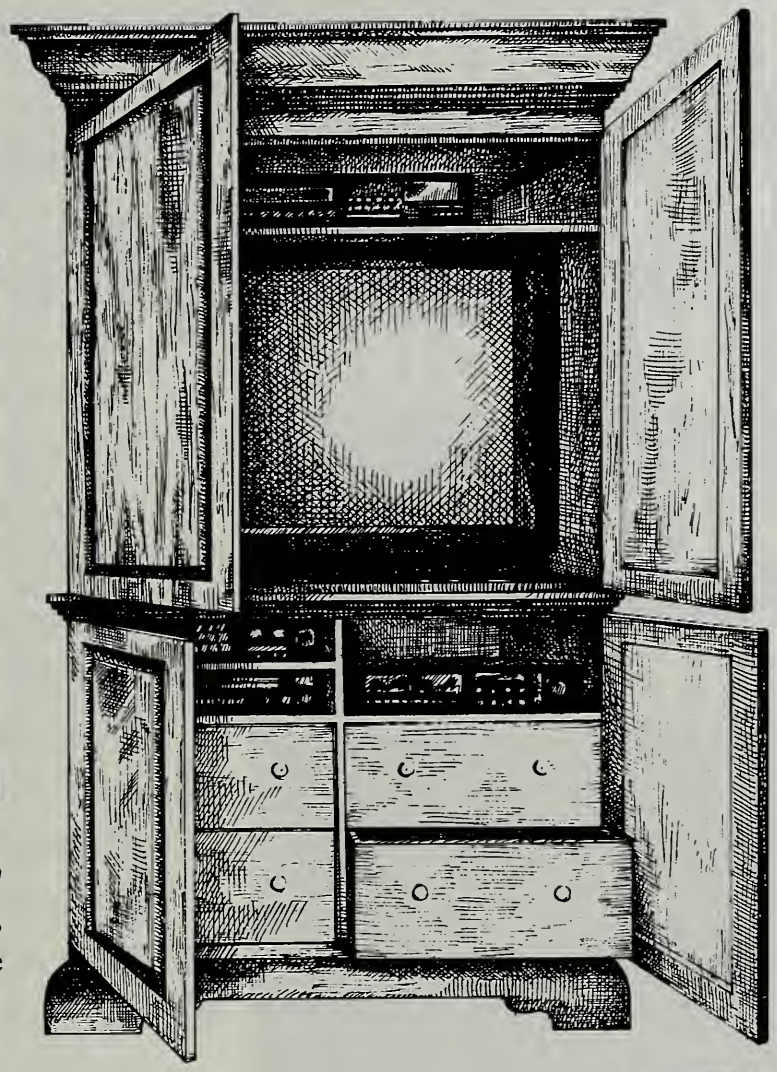

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Addressing the State's Need for Primary Care

Geoffrey Goldsmith, M.D., M.P.H.*

Scope of the Problem

Our state's primary health care system is hurting. Almost every component essential to primary care services is under pressure. Some communities lack adequate hospital facilities. About 20% of Arkansans do not have sufficient financial resources to pay for health care. There are major gaps in the state's emergency care system and a major problem of transporting patients to health care providers. But unless solved, the state's severe shortage of primary care physicians, especially in rural areas, will erode the value of all other attempts to make primary health care more available and accessible to the citizens of Arkansas.

In 1990, the Arkansas Office of Primary Care's health manpower study pointed out that 72 of 75 counties were designated in part or total as primary care medically underserved areas. This shortage of primary care physicians is despite the outstanding record of expanding the number of Arkansas primary care physicians by 52% in the 1980s. Currently, there is a shortage of approximately 300 primary care physicians in Arkansas. Furthermore, it has been estimated that approximately 20% of the state's primary care physicians are nearing retirement age. The Office of Primary Care also found that there is a significant shortage of physicians providing obstetrical services in rural counties.

The University of Arkansas for Medical Sciences (UAMS) has addressed the primary care physician shortage with foresight and began to develop a family practice residency training system approximately two decades ago. There are now six (soon to be seven) family practice residency training sites in the state. The UAMS College of Medicine has emphasized family practice training in its curriculum and is, in fact, among the leading medical schools in the U.S. in the percentage of graduates entering family practice residency. The state has adopted loan forgiveness programs for primary care physicians who enter rural practice and has made a major commitment to family practice education through the fine Area Health Education Centers.

All of these efforts have helped the state add significantly to its primary care physician manpower, but as mentioned above, the state's shortage of primary care physicians continues to be acute especially in rural areas. A number of key issues must be addressed to rectify the current shortage of primary care physicians in Arkansas.

Encourage Medical Students to Enter Primary Care Training

More students should be encouraged to pursue careers in primary care. How we recruit college students into medical school needs to be scrutinized so that more students who are inclined to enter primary care are encouraged to apply for medical school. Such outreach recruitment activities should be started as early as high school with active involvement of the local pri-

* Dr. Goldsmith is Garnett Professor and Chairman with the Department of Family and Community Medicine, College of Medicine, at the University of Arkansas for Medical Sciences in Little Rock.

mary care physician in recruitment. This is not to suggest that the medical school admission process cease to recruit the future medical researchers, surgeons, and medical sub-specialists. Even if the admissions policy were changed in order to select medical students who are more likely to enter primary care specialties, this strategy alone might not lead to a substantial increase in students selecting primary care for several reasons.

Many factors influence specialty choice during medical school and are beyond the reach of the admissions committee. For example, some specialities better meet the student's financial expectations, talents, and interests. Furthermore, medical school physician role models can have a powerful impact on student specialty choice as can the students' perceptions of prestige and scientific basis of various specialties. Up to 50% of medical students change their mind about specialty choice during medical school. The goal then is to make primary care more attractive before, during, and after medical school.

In order to address the financial disparities between primary care and other specialties, elected officials, medical societies and private insurers must endorse strategies which accelerate and expand ongoing efforts designed to reduce the reimbursement gap between cognitive oriented and more procedurally oriented specialties. Every effort must be made to orient medical students about the shortage of primary care physicians and the indeed over supply in some specialties. Primary care is professionally and emotionally rewarding and this message needs to go out to the pre-medical advisors. This message is being delivered to medical students by primary care physicians and others throughout the four years of school. Recent expansion of the UAMS medical student training into the community through the required community based family practice clerkship may even further strengthen the image of primary care.

The academic programs in primary care provide high quality clinical education. One additional way primary care physicians can enhance their image as being on the cutting edge of medical science, both within the academic setting but also in the community, is to be more involved in office based research. Efforts are under way by the Department of Family and Community Medicine to reach out to our community colleagues to participate in clinical research.

Increase the Number of Primary Care Residency Trainees

Growth in the number of primary care training slots is critical in order to meet the existing demand. If national health insurance increases the affordability of primary care, the increase in primary care residency slots must occur even more rapidly.

Maintain High Stature Residency Training Programs

We need to demonstrate to medical students the value society places on primary care residency training. Fine facilities, outstanding training, the latest and best clinical equipment has been supported within the state's family practice training sites. To help alleviate the financial burden on medical students who seek primary care residency and to emphasize the importance society places on primary care, there should be increased salaries for primary care residents and more support for trainees to enter rural practice.

Strengthen Incentives to Participate in Obstetrics

With the shortage of obstetricians within the state, residencies in family practice have made special efforts to train residents in obstetrics. If most of the family practice residency graduates and the majority of practicing family physicians were to provide obstetrical care, there would not be a shortage of physicians providing obstetrics in the state. Studies from other states imply that in order to encourage family physicians to continue delivering obstetrical care after training, there must be a number of changes. This includes significantly lower malpractice insurance rates, better reimbursement, readily available specialist back up, and a way to share the obstetrical workload.

Recruit and Retain Rural Primary Care Physicians

Researchers have studied the most important factors for recruitment to rural practice. Quality of life, family ties, location where the physicians and spouse "grew up," and size of the community, were all found to be associated with the physician selecting a rural practice site. The dire shortage of rural based primary care physicians requires the marketplace, hospitals, academia, state government, community based primary care physicians, and federal government singly or together to focus on the problem of recruiting physicians to rural communities. There are several very positive examples of activities within the state which support recruitment to rural practice.

The staff of two state agencies, Office of Primary Care and the Office of Rural Health, meet with residents to orient them to rural practice opportunities and to financial support offered by the state for rural primary care. They soon will begin to offer practice management assistance to primary care physicians establishing rural practice. The UAMS Department of Family and Community Medicine is establishing an endowed professor-

ship in rural family medicine named in honor of Ben Saltzman, M.D. to lead the department's new Division of Rural Health. Many academic departments at UAMS have extensive outreach programs.

UAMS has established a Center for Rural Health which is mobilizing all the resources of UAMS; medicine, nursing, allied health, pharmacy, and the University Hospital in order to aid rural health care. This effort includes linking rural-based primary care physicians with specialist consultants to lessen professional isolation of primary care physicians, and to provide continuing education. The larger hospitals are also reaching out in creative ways to rural communities. Progress is being made by the University Medical Center and state government to support rural health care and these efforts will probably need to grow.

Retaining primary physicians in rural communities is equally important to recruitment. For example, one study showed that the majority of the primary care physicians recruited to rural areas through the federally subsidized National Health Services Corps leave the practice site within five years. This study found that critical to retention of physicians in rural areas are the physician's salary level, a sense of appreciation by the community, availability of other physicians to share call and to provide consultation, and some affiliation with a medical school in a research or teaching capacity. We need to develop creative strategies to retain rural primary care physicians in their communities.

Arkansas Physicians Can Help Address the Primary Care Shortage

All Arkansas physicians can assist in rectifying the primary care physician shortage. Certainly primary care physicians serve as informal role models for their high school aged patients. Primary care physicians should go one step farther and volunteer to speak at high schools and invite high school and college students into the office to work during the summers.

All physicians can advocate for changes in the reimbursement system which provide better reimbursement for cognitive services. Physicians can volunteer as teachers at the state's family practice residencies and family physicians might consider serving as office based preceptors for UAMS's extensive community based medical student training programs. It will take all of us working together to solve the primary care shortage.

Conclusion

The positive efforts to support primary care have lead to a significant increase in the number of primary care physicians practicing in Arkansas. Involvement of community based physicians, communities, the marketplace, government agencies, and academic groups will be required to solve the shortage of primary care physicians in Arkansas. ■

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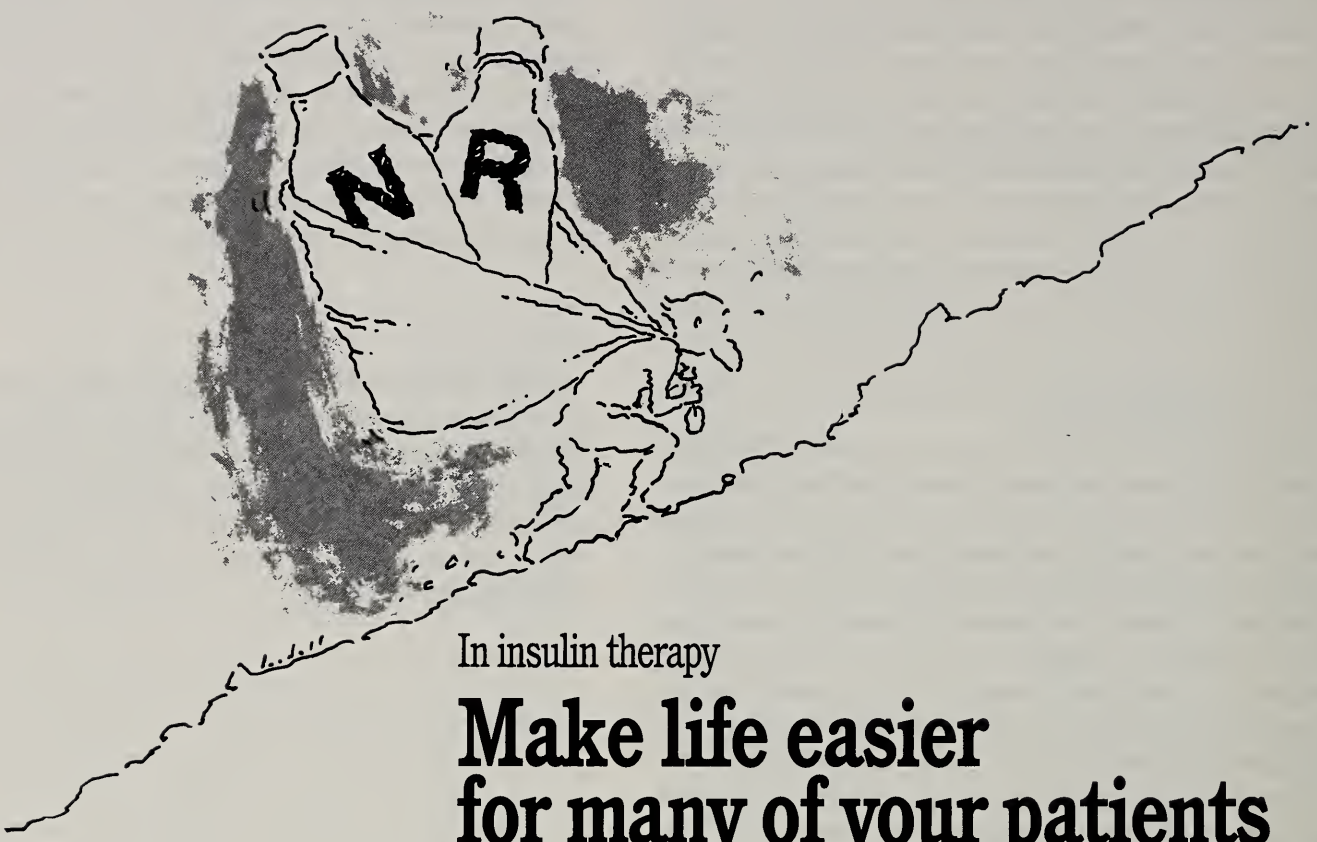

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Knowledge of Chemical Abuse and AIDS Among Gifted Junior High School Students in Little Rock

H. Stefan Bracha, M.D.,* Adam S. Bracha**

A 12-question test was composed and administered to the seventh, eighth, and ninth grade Gifted-Talented (GT) Science Classes. A clustered stratified random sample of 66 students was selected out of the 194 students. The mean score was 70% for the eighth grade, 68% for the seventh grade, and 62% for the ninth grade. Knowledge among the students was especially deficient regarding the risk of legal drugs of abuse, i.e., cigarettes and alcohol.

According to the Partnership For A Drug Free America (PFDFA), every American sees an average of one anti-drug message per day.[1] Therefore students should have some basic knowledge about the dangers of drugs, smoking, alcohol, and AIDS. To put this knowledge to the test, we composed a 12-question test (Table 1) based on written material gathered from a compendium of assorted newspapers articles about health issues and written material received from educational organizations.[1,4,5] The questionnaire included four questions on alcohol, three each on smoking and AIDS, and two on drugs.

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** Adam S. Bracha is a student at Dunbar Magnet Junior High School in Little Rock, Arkansas.

Methods

Random sampling: We drew a clustered stratified random sample[2,3] by picking one Gifted Talented (GT) science period from each grade and administering the questionnaire to the entire group simultaneously. Since the students were not pre-assigned to the periods by any specific method but were free to choose if their schedules permitted, we randomized the choice of the period by picking it using the raffle method. Therefore, one can assume that measurable characteristics as the level of science knowledge, age range, proportions of boys/girls, and race are the same in each class of the same grade.

Subjects: Dunbar International Studies Magnet Jr. High has a population of 194 GT science students. Seventy-one are in the seventh grade, 73 are in the eighth grade, and 50 are in the ninth grade. The questionnaires were administered by one of the authors (ASB) to sample classes on the same day during class. Twenty-four students in the seventh grade (34%), 22 in the eighth grade (30%), and 20 in the ninth (40%), completed the questionnaires for a total of 66 students or 34% of the total GT science student population.

Results

The facts about the dangers of smoking and drinking were the least well known. The facts that one gets drunk as fast by drinking one kind of alcoholic drink as by mixing different kinds, and that a six pack of beer and

Table 1. Percent of Correct Answers Given by Students

1.	In cigarettes, nicotine is more dangerous to your health than smoke	NO - 30%
2.	A six pack of beer has the same amount of alcohol as six glasses of wine	YES - 30%
3.	It is easier to get drunk by mixing two different alcoholic drinks together	NO - 33%
4.	Smoking cigarettes is as dangerous as doing drugs	YES - 53%
5.	A medical doctor can help you quit smoking	YES - 61%
6.	Tobacco usually can get you started on drugs	YES - 68%
7.	AIDS is transmitted by exchanging body fluids with someone who has AIDS	YES - 82%
8.	Doing drugs causes permanent brain damage	YES - 82%
9.	The drinking age in the state of Arkansas is 21	YES - 82%
10.	Drunk driving is the leading cause of car accidents	YES - 91%
11.	It is possible to carry the AIDS virus without knowing it	YES - 92%
12.	Only homosexuals get AIDS	NO - 96%

six glasses of wine have the same amount of alcohol were frequently missed. The fact that teenage smoking is often the first step toward drug abuse was little known (nicotine and alcohol are considered to be "gateway" drugs). Only 50% of the students knew that smoking is as dangerous to your health as abusing drugs. Only 30% knew that the smoke is more dangerous than the nicotine in cigarettes, and only 60% knew that a medical doctor can help you quit smoking. The students in all three grades responded most accurately to the AIDS questions.

The eighth graders did the best followed by a narrow difference by the seventh graders. Out of this total, the seventh grade students scored 814/1200 (68%). The eighth grade scored 837/1200 (70%). The ninth grade scored 745/1200 (62%). The three combined scored 800/1200 (67%). The percent of correct answers for each question is shown in Table 1.

Discussion

This brief survey of the top students in an urban public high school in Arkansas suggests that the AIDS education campaign and the anti-drug campaign conducted by the school and media results in an adequate knowledge level. However, this is not the case regarding the dangers of legal addictive drugs (e.g. smoking and alcohol). The knowledge level among average (non-gifted/talented) students is likely to be even lower. Much work needs to be done in teaching the students about the dangers of these two substances.

We found no difference in the knowledge base of seventh and ninth graders. This is consistent with previous research showing that while younger children today have strong anti-drug attitudes, older teenagers may be less cognizant of the dangers of using illegal drugs, smoking, and drinking alcohol.[1] More educational effort may needed to reinforce knowledge about smoking and drinking, especially among older teenagers in Arkansas.

Acknowledgement

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References

1. Partnership For A Drug-Free America, Mission Statement NY, 1986.
2. Parl, Boris, Basic Statistics, Doubleday NY, 1967.
3. Rowntree D. Statistics Without Tears, Charle's Scribner's Sons NY, 1981.
4. Eleanor Goldstein, Ed., Health, Vol. 3, 1984-1988, Social Issues Resources Series Inc., Boca Raton FL, 1989.
5. Eleanor Goldstein, Ed., Alcohol, Vol. 3, 1984-1988, Social Issues Resources Series Inc., Boca Raton FL, 1989. ■

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On The Other Side

Author Anonymous*

On a Wednesday afternoon in May, I was admitted into the hospital as a sick 34-year-old, married mother of three girls. I was cared for by concerned, kind and caring nurses. The nurses got me comfortably into bed, took my vital signs and started an I.V. This lasted approximately 12 hours, and then the endless nightmare began.

The following morning changed my whole life. My surgeon had decided to do an exploratory laproscopy and a probable laprotomy Friday. We had discussed the lengthy duration of my illness, multiple tests I'd received, and my extreme weight loss. He then asked me if I objected to taking an HIV test - which of course I didn't - knowing I had nothing to worry about. However, I was worried and very afraid of the upcoming surgery. Neither the doctor nor myslf expected the ignorance and inhumane treatment I was about to receive by consenting to having an HIV test. I must include that my doctor (surgeon) is the most compassionate and caring physician that, during the course of my illness, I have met. Both he and his two nurses were great throughout this very unfortunate ordeal.

Just after the doctor left, one of the nurses came into my room with a consent form for me to sign. This form gave the hospital permission to test me for HIV and to contact our insurance agency. The nurse told me it was a law, and I had to sign the consent form. I questioned her about both. I wanted to know why they had to contact our insurance company, and I had never heard of such a law. She crudely said, "Sign it, it will all leak out anyway." I thought to myself, "What will leak out?" In a short while she returned to my room to assure me "it" wouldn't leak out from the hospital!

This was the beginning of a three day nightmare. By consenting to taking an HIV test, it was presumed I had AIDS, proven by the treatment I received.

As a senior nursing student, I was taught to always wear gloves, regardless of the patient's illness. This is practicing safety for both the patient and nurse. However, in my case, prior to the HIV test gloves were not worn once, not even to start my I.V. On Thursday, however, after the HIV test was on my chart, OSHA rules went into effect. News of the HIV test ran rampantly throughout the hospital. Gloves were now worn to take my vital signs and even to wheel me to x-ray. Nurses' facial expressions changed from concern to both fear and disgust. I received stares from the hallway, my sheets weren't changed Thursday, and I was moved into a private room after surgery Friday.

Thursday evening I wanted to bathe and wash my hair, knowing after surgery on Friday it would not be possible for a few days. This simple request turned into a "battle for a bath." Three or more nurses were all in my room telling me no. The excuse they gave me was that "I might get my I.V. site wet and another would have to be started." At this moment, my I.V. pump began to beep. The pump read "I.V. dry, occlusion in line, air in line" and the I.V. tubing had collapsed near the needle. All of this was causing blood to back up into the I.V. line. I said, "Good, now you can take the I.V. out since it will have to be restarted again. I can take a bath and put clean

* The author of this article wishes to remain anonymous, at this time, in order to protect herself and her family from any other undue publicity.

pajamas on." I was wrong; no nurse was about to touch the I.V., even though the blood was backflowing, the line collapsed and the air bubbles had all scared me to death! At this moment, I no longer felt human. I felt like a germ, wanting to run as far away and as quickly as I could.

My battle for a bath continued. Although I didn't get a bath, I did receive a clean towel, wash cloth and a garbage bag to wrap my I.V. site. A nurse showed me to the shower and left. Aware I was too weak and feeling it was unsafe to shower alone, I quickly opened the door, asking her as she walked away, to please get my husband. My husband came into the shower fully dressed, and helped me wash my hair and shower. I suppose they thought a shower would be easier to disinfect, but the shower was better than nothing. The original concern of getting my I.V. site wet, and the difficulty in accomplishing a shower, did put me at a greater risk of both getting the I.V. site wet and falling in the shower.

After my husband left, I really began to feel alone and afraid. It was God, me and an endless flow of tears. I began to cry not only for myself and AIDS patients, but also for the many other patients, each with a different illness. I began to wonder how all patients were being treated. I could not believe we lived in such an uneducated and inhumane world.

In nursing school, I was taught to treat all patients as individuals, with courtesy and thoughtfulness. Respect for each person's dignity and worth is essential to good healthcare. Regardless of the illness, all patients should be treated with concern and compassion. I had never been taught to push the patient away into isolation, fear and loneliness the way I had been pushed away. This pushing away by healthcare professionals in a hospital was causing me to give up, and I wondered how many others were also doing the same.

I cried most of that night, unable to sleep. Each time the nurses made rounds, they would put their gloves on to take my vital signs, scrub and then go to the patient next to me without gloves to take her vitals. I continued to feel dirtier and angrier. I went out into the hall searching for the floor RN, needing to release my feelings. I found an RN and told her how I was being treated and wanted to know why. She was sorry I felt bad but assured me this type of reaction towards HIV was normal in our little town. The RN explained that this hospital had little experience with HIV, and the nurses weren't trained enough about to HIV to react in any other way. I found out later that a young man had died with AIDS, just about three weeks prior to my admission, in this hospital. When I attempted to explain to her that my risk factor was as low as one could be for a positive HIV, she said the doctor had ordered it for a reason and it was very obvious there was something wrong with me. I then asked her why no gloves were worn prior to the HIV test appearing on my chart. She quickly began to tell me how healthcare professionals put their lives on the line for patients. My suggestion is that if they are not educated enough to know how you contract AIDS, which is not by pushing a patient in a wheel chair, etc., they get educated or that they find another profession. This RN must have spread the complaints I voiced to the other nurses. The justification of glove wearing began - OSHA rules and fines? Why didn't OSHA and fines matter before the HIV test appeared on my chart?

Friday morning was more of the same type of ignorance and inhumanity, all the way up until time for surgery. My room-mate was discharged that morning, and I requested her window view bed. The nurses went back and forth finally saying, "Yes, but we will have to move your whole bed." They moved my bed, changed my linens wearing gloves (OSHA), and then put my clean linens on after taking their gloves off! The aide doing this had visible sores on her arms and hands! No gloves were worn to change the other beds.

When I awoke from surgery Friday afternoon, my first words were, "Doctor, they think I have AIDS." I didn't even - or at that point care - what he had found in surgery. I told him this in the presence of two of the nurses who had treated me so badly. They both tried to deny it was them, but I assured him that it was. Anger appeared in his face, as he told them why he gave me the test in the first place. I am quite sure they had a discussion afterwards.

Later that evening I was moved (not at my request) to a different floor and into a private room. The nurses first tried to tell me I had requested the move, which was not true. During admissions I had requested a semi-private room, because our insurance did not cover private rooms. They then left and returned to say that the doctor had made the request.

This move was great because of a nurse and a wonderful lady named Francis. She has been a nurse for 40 years and still is what a nurse should be. She touched me, held my hand, listened to me cry and she sincerely cared. It was her inspiration and love that helped me survive this nightmare. I went to the chapel and said a prayer. My prayer was to allow me to forgive the ignorance, and for God to help health professionals and all people to become educated about AIDS and other diseases.

That was May; it is now July. My healing process has been slow. I have no doubt that the HIV episode drained me both emotionally and physically. I spent too much energy on the unimportant things such as getting a bath, respect, etc., when I should have spent this energy on getting well.

Even though Saturday morning my HIV test came back negative, my nightmare was not over and never will be. I was still emotionally and physically drained.

I was very sick and had lost many hours of sleep because of this nightmare. The director of nursing came to my room to try to "justify" what was done to me "unjustly." Many nurses also tried to excuse their behavior and apologize for what had happened. No one ever could explain this behavior and admit it was truly wrong, which is what I wanted to hear. People don't change overnight. Ironically, they took their gloves off again - now knowing I didn't have AIDS. I found this both insulting and once again ignorant. I didn't have AIDS, but I did have an incision on my abdomen and the last thing I wanted or needed was an infection!

After being discharged, the nightmare continued. I called the hospital administrator at home so I could make an appointment with him. I wanted to be sure this horror story made it to him and was not stopped in between. I had tried on several occasions to locate him in the hospital with no luck. When my husband and I arrived at his office, we had to wait a few minutes. The director of nursing was trying to give him a or his version of the story. The administrator listened to our story while taking a few notes. To make a long story short, he basically repeated what the director of nursing had already told me. He apologized and we left satisfied we had met with him; but dissatisfied as to what changes would be made to correct these problems.

Nothing will ever change the fact that I had to come home to my kids and tell them, "If you hear I have AIDS, I don't." In a small town like this, gossip is something to pass the time away. I feel like I have to carry around my HIV test results, as I do my driver's license. Privacy and confidentiality should be enforced in a hospital. My big concern is that if patients continue to receive this type of treatment, and we don't educate health professionals about AIDS and HIV testing, people will not take the test.

I am asking all of you who read this to join hands and help to end this nightmare. Please get involved, it takes a team effort to win any battle. Be a human being that cares about all of our fellow men and women. There are many agencies waiting for your call to help. You don't have to have a special talent to care, and you can volunteer to do the job best suited for you. We need to raise money for research. We need to let our government know that this has to be done. If we don't become involved, many of us will watch our friends and loved ones die. We desperately need to educate our youth. We have telethons for numerous diseases, let's include AIDS.

Until we do find a cure or a vaccine, we have to all do our part to help prevent new cases of AIDS. My prayer is we will conquer this deadly virus, along with many more of the other diseases. Remember, though, that until this time we have to treat AIDS and all patients with love and dignity. After being "on the other side" I can assure all of you this is not a place any of us would ever want to be. ■

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Coalition for a Healthier Arkansas

Steering Committee William N. Jones, M.D., Chairman

Tobacco Tax Petitions Certified for the November Ballot

The Coalition for a Healthier Arkansas' proposal to place on the November ballot a 25 cent increase on a package of cigarettes was certified Friday, August 7, by the Secretary of State.

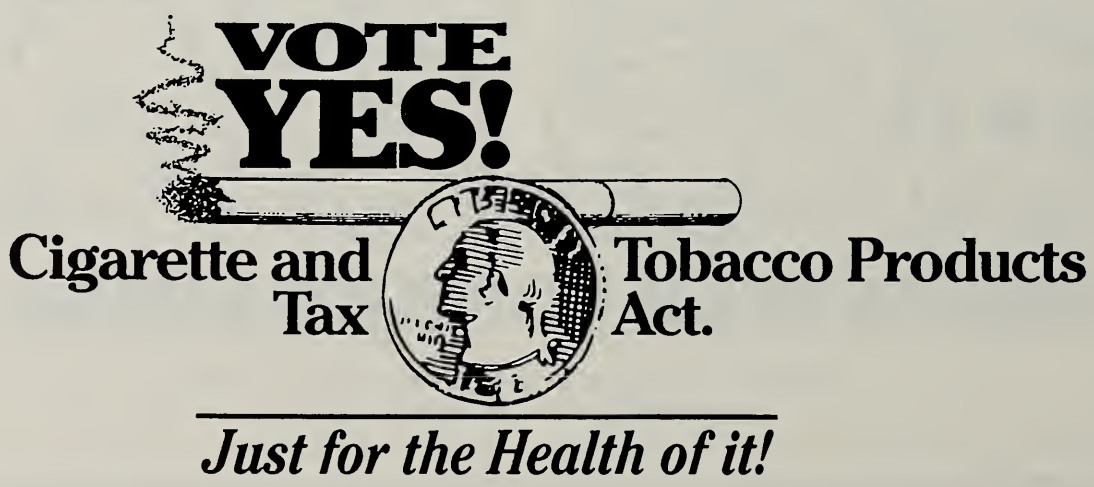
The Coalition, on July 1, turned in to the Secretary of State's office more than 70,000 signatures. To be certified for a position on the ballot, 55,713 signatures had to be verified as registered voters. CHAR ended up with an unusually high number of valid signatures, some 82% or more than 700 signatures above the minimum total.

Dr. William N. Jones, chairman of the Steering Committee of CHAR, said he was gratified to learn of the certification.

"First it's gratifying to know that volunteers and dedicated citizens can still make a difference in the political process." The Coalition, he said, "is a group of almost 60 organizations who are dedicated to improving the health of all Arkansans," adding that "in a day when political commentators lament the lack of public interest in the democratic process, it is encouraging to see commitment and concern carry the day in Arkansas."

Dr. Jones expressed his appreciation to the Secretary of State's office for their thorough check of his group's petitions, and said that he believed certification proved his group's contention that they had run the cleanest petition drive in the history of the state. Tobacco interests have made various charges against the petition drive, but Dr. Jones has consistently maintained that his group had nothing to fear from their investigation.

"We are certain that we have not heard the last of tobacco. We expect they will continue to funnel money into Arkansas and seek to win in court what they can not win at the hands of the people," Dr. Jones said. "Just as we faced certification with confidence, we also face any court challenge with confidence," Dr. Jones concluded.



Tobacco Industry Targets Children, Working Women and Minorities

Spokesmen for both the Arkansas State Police and the federal Treasury Department's Bureau of Alcohol Tobacco and Firearms said recently that bootlegging of tobacco products such as cigarettes has posed no problem between Arkansas and any adjacent states.

That is true, agency spokesmen added, even though Arkansas's current 22-cent state tax on each pack of cigarettes sold varies widely from the state taxes charged by such states as Texas (41 cents); Oklahoma and Mississippi (18 cents); Louisiana (16 cents) and Missouri and Tennessee (13 cents).

When additional state tobacco products taxes are proposed, as has occurred in Arkansas with the 25-cent increase suggested by CHAR, the tobacco industry typically opposed the surtax, arguing that cigarette bootlegging will result, leading to an incursion by elements of organized crime and other undesirables.

Such bootlegging has not happened, however, in California where, in 1988, citizens raised that state's cigarette tax by 25 cents a pack, from 10 to 35 cents.

In Eastern tobacco producing states - Kentucky, the Carolinas and Virginia - the tobacco economy is encouraged by the nation's lowest tobacco taxes, ranging from 2.5 cents in Virginia to 7 cents a pack in South Carolina.

Sgt. Van Dyer, public information officer for the Arkansas State Police, said in a recent interview, "In Arkansas at least, the real crime is not cigarette bootlegging....The real crime here is the illegal sale of cigarettes to children - those younger than age 18." Dyer said Arkansas and 42 other states, aware of the health hazards associated with smoking, make it illegal to sell cigarettes to minors.

Yet, recent studies estimate that about 3% of tobacco company's annual profits have come from the industry's $221 million worth of sales of cigarettes each year to children and teenagers.

Recently, such advertising campaigns as RJR/Nabisco's "Joe Camel" efforts have been roundly criticized by Antonio Novella, the U.S. Surgeon General, and by officials of the American Medical Association as being thinly-veiled attempts to enlist teenagers into the ranks of American smokers.

The tobacco industry, plagued by annual loss of thousands of its best customers either to smoking cessation or to death, has unabashedly targeted children, working women and minorities as prospective smoker replacements. ■

COALITION FOR A HEALTHIER ARKANSAS

P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

Dear C.H.A.R. Campaign Chairman:

I have read about the upcoming campaign for an initiated act to further tax tobacco sales in Arkansas, and I want to help all I can before the November 3rd vote.

Please contact me as a volunteer to:

__ Display yard signs at my home or office.

__ Help set up and direct a county campaign headquarters.

__ Participate in a campaign speakers' bureau for civic clubs and other community groups in my vicinity.

Enclosed please find my check (or money order) in the amount of:

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$250 _____ $100 _____ $_____

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Mailing Address _____

City _____ State _____ Zip _____

Phone _____ _____
(day) (evening)

COALITION FOR A HEALTHIER ARKANSAS

P.O. Box 251505, Little Rock, AR 72225-1505 **(501) 663-SMOK**

The following physicians have contributed to the Coalition for a Healthier Arkansas, an effort endorsed by the Arkansas Medical Society. If you would like to add your name to the list of supporters, complete the pledge card on the bottom of page 137 and return it to CHAR.

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Arkansas Allergy Clinic of Little Rock
H. Daniel Atwood, M.D.
Scott Bailey, M.D.
Jeffrey Barber, M.D.
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- Arkansas Association of Area Agencies on Aging
- Arkansas Association of Home Health Agencies
- Arkansas Blue Cross and Blue Shield
- Arkansas Cancer Research Center
- Arkansas Dermatological Society
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- Arkansas Perinatal Association
- Arkansas Pharmacists Association
- Arkansas Public Health Association, Inc.
- Arkansas Society for Public Health Education
- Arkansas Speech-Hearing-Language Association
- Arkansas State Board of Health
- Arkansas State Dental Association
- Arkansas Thoracic Society
- Arthritis Foundation, Arkansas Chapter
- Campaign For Kids Coalition
- College of Medicine Faculty, University of Arkansas for Medical Sciences
- CARTI
- Governor's Advisory Council on Aging
- Lost Chord Club of Central Arkansas
- March of Dimes Birth Defects Foundation, Arkansas Chapter
- Medical Equipment Suppliers Association of Arkansas
- Mental Health Council of Arkansas
- National Association of Social Workers, Arkansas Chapter
- The Presbytery of Arkansas
- Presbyterian Urban Council
- Retired Senior Volunteer Program
- United Methodist Church, Little Rock Conference
- United Methodist Church, North Arkansas Conference
- Youth Home, Inc.

OR ONE OF THESE?

BIG, POWERFUL TOBACCO COMPANIES

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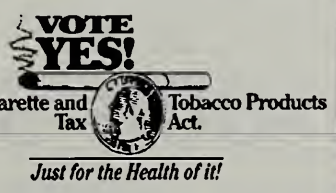
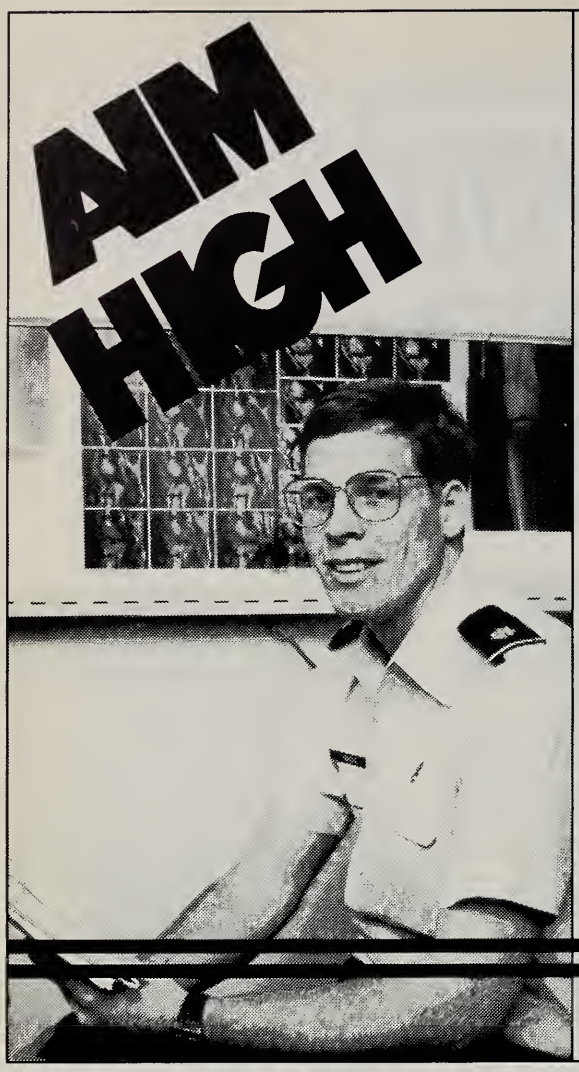
(Think about it.)

This message brought to you by your friends at the Coalition for a Healthier Arkansas, Russ Rawn Treasurer





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Tobacco's New Adversary

David S. Bachman, M.D.*

For many years, the tobacco industry has defended their "instruments for death" against onslaught of the health societies.

Though the advocates for a healthy life have fought valiantly, and not without success, the battle has been most difficult.

Through mega bucks, the tobacco industry has been successful in denying the indisputable health dangers of tobacco use - largely because of the immense amount of money spent by the tobacco war lords in advertising their products and doling out large sums of money to politicians on a state and national level for protection of their interests.

The fight between health and tobacco interests is reminiscent of the valiant attempt of natives in warding off enemy tanks with spears during the Ethiopian-Italian War.

That old saying, "money talks" has been the battle cry of the tobacco industry for years. Their shield of protection.

Cigarette companies spend over $3.27 billion a year in an attempt to maintain the current group of cigarette smokers and to expand the market. Their advertising budget increased 27% in 1988 alone.

Financial outlay of the combined health forces is but a fraction of tobacco's expenditure.

Despite this monetary disparity, remarkable progress has been made by the advocates for health toward a smokeless generation.

There are approximately 50 million remaining smokers in the United States. Many feel they represent the hard core group - those most resistant to smoking cessation.

A multi billion dollar giant, other than tobacco, has eyed this group. They see enormous potential profit in providing a product that will not only take the tobacco monkey off their backs but the smoker will be comfortable in doing so.

Since at least 80% of smokers have expressed a desire to stop smoking, the product is most appealing.

Who is this giant and what is their product?

It is the pharmaceutical industry and their product is a nicotine patch.

A unique high stakes battle is shaping up between two industrial giants - winner take all.

The tobacco industry will stop at nothing in supplying their drug of dependence, nicotine, to addicted customers.

On the other hand, the pharmaceutical giants will leave no stones unturned in selling their substitute, but safer drug, nicotine patches.

Unlike health societies, the pharmaceutical boys have the mega bucks to push their product and they have an attractive substitute for cigarettes.

We have a death struggle in the making. Tobacco interests fighting desperately to retain customers and the drug companies attempting to entice the 50 million smokers to trade their cigarettes for nicotine patches.

The possibility of selling a drug to 50 million needy people must be mind boggling to the legitimate drug industry. Undoubtedly they are willing to spend vast sums of money for advertising and promotion to attain their goal.

---

* Dr. Bachman practiced as a general surgeon and brochoesophagologist at the Millard-Henry Clinic in Russellville for 20 years. He is now retired.

The tobacco industry has never before had such a formidable adversary.

The stakes are large for both sides - patch replacement can mean the death of the tobacco industry; if the patches replace cigarettes, the product eventually will no longer be needed. If so, like the high roller, the legitimate rug people must make their profits in a hurry then go to greener pastures.

If the patch does not catch on, monetary loss will be sizable.

The tobacco industry, keenly aware of their rich adversary, is beginning to cry and complain. They are claiming the "patch" is a money making gimmick.

That is a very true; however, it will save countless lives, prevent unnecessary disease and untimely deaths - those are worthwhile gimmicks.

Footnote

A behavior modification program consisting of six weeks (one session per week) should be included with the use of the nicotine patch.

Smoking consists of two types of addiction - pharmacologic and psychologic. The patch deals with the pharmacologic component. Behavior modification is necessary in dealing with the psychologic component.

Unless the smoker's lifestyle is not changed, resumption of smoking will occur - patches or no patches. ■

TAKE THE FIRST STEP TO RECOVERY

The Arkansas Medical Society Physicians' Health Committee is interested in the well being of Arkansas physicians. Through effective intervention, treatment referral and monitoring of health conditions, the Physicians' Health Committee's services enable physicians to continue to deliver safe and effective patient care.

The Committee is composed primarily of physicians who "have been there" and want to help their colleagues from making a mistake.

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$35,000 - $75,000	.0331	.0218
$75,001 +	Call for quotes	

EXAMPLE: $10,000 x .0229 = $229.00 per month

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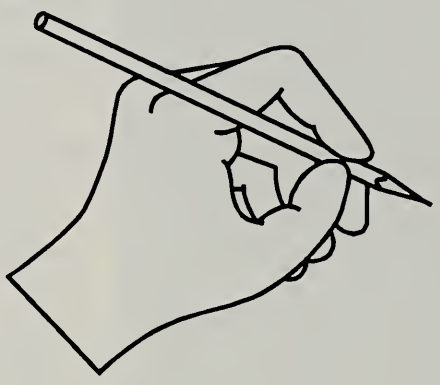

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So You Want To Live To Be 100?

F. Hampton Roy, M.D.*

Since the beginning of time, man has been searching for eternal life.[1] Many scientific studies have been conducted to find an anti-aging remedy. Experiments have been done with DNS, RNS, SOD, and other substances but none of these have proven effective in life extension.

Over the course of history, the life expectancy of a human has steadily increased. In Roman times, the life expectancy was 30. Today the life expectancy is in the mid 70's. This is probably caused by better medical practices, better hygiene, and nutrition.

Further improvements in life span will probably include changes in the diet, exercise, and the use of antioxidants and vitamins.

In researching the book Encyclopedia of Aging, I read a lot about life extension.[2] The purpose of this paper is to discuss longevity.

In the 1980 census, it was found that 25,000 United States' citizens were over 100 years of age. The census bureau estimates that the number of centenarians by 1985 had grown to 45,000. By the year 2000, the estimates for the number of centenarians is about 100,000. By the year 2080, there could be 19 million centenarians.

Dr. Edman Palmore of Duke University Center for the Study of Aging and Human Development, has found that the best predictor of longevity for men over age 60 is satisfaction in their work or volunteer activities. For women of the same age, it is the ability to function physically.[4]

Other predictors of longevity are being happy, avoiding tobacco, and enjoying sex. Less active people, and those in poor mental and physical condition, tend to be older than their years. Studies at the Normative Aging Study in Boston support the belief that people who appear to be biologically older than their years, actually are and, in fact, may stand a greater chance of dying sooner.

The increase in the number of the elderly in many countries has created the need to investigate the reasons for this longevity. Studies seek to identify the economic, demographic and social consequences of this phenomenon and to help in the search for solutions to the problems it raises in fields such as medicine, housing, and social services.

One region where people of great age are found is in the Caucasus in the Soviet Union.[5] While only 7% of the USSR population lives in this area, 16% of the country's elderly and 35% of those of 100 years of age or older are found here.

Research shows that group longevity is determined by a combination of factors:

1. Ecological factors — a subtropical climate to which the population has biologically adapted in the course of many generations.
2. Genetic — some aspects of this adaptation have been reinforced genetically and transmitted to their descendants.
3. Morphological characteristics — small stature and muscular constitution.
4. Diet — little meat and hardly any animal fats, salt or sugar; they consume lots of milk products (especially cheese), fruits and vegetables.
5. Environment — generally live all their lives in the

* Dr. Roy is an ophthalmologist with the Arkansas Cataract Center in Little Rock.

place where they were born.

6. Work — have always done the same kind of work, in farming or in the home, and continue to work as long as their strength permits.
7. Social — still see circle of friends and participate in various social activities.

The environment of city life seems to affect the elderly more negatively. One main factor is that in retirement they are not able to continue the type of work that they performed all their lives and experience a complete change in their daily lives. Those living in rural areas also seemed to maintain closer ties with family and friends.

Researchers at the University of California at Los Angeles, led by Dr. Lester Breslow, found that the healthiest people followed seven habits:

1. Never smoke cigarettes
2. Get regular physical activity
3. Use alcohol moderately or never
4. Sleep seven or eight hours each night
5. Maintain proper weight
6. Eat breakfast
7. Avoid eating between meals

Other doctors add to this basic list. Dr. Edward W. Capion, head of geriatrics at Massachusetts General Hospital in Boston advises, "Avoid undue amounts of emotional stress, control blood pressure, and use reasonable caution in automobiles."[5]

Hobbies and good reading habits may help. But Dr. Richard W. Besdine of Harvard maintains, "Work is best. It doesn't have to be the same work you did all your life. But is has to be something that keeps your mind busy and makes you feel useful."

References

1. Kinney T. "Living Longer." In AGING, ed. Goldstein, E.C., Vol. 3, Art. 10. Boca Raton, FL. Social Issues Resource Series, Inc. 1981.
2. Roy FH, Russell C. The Encyclopedia of Aging and the Elderly. 1992, Facts on File, New York.
3. Thompson L. "After Age 30, Survival is Infinite." In AGING, ed. Goldstein, E.C., Vol. 3, Art. 17. Boca Raton, FL. Social Issues Resource Series, Inc. 1981.
4. Brocklehurse JC. Textbook of Geriatric Medicine and Gerontology. 1985, Churchill Livingstone, New York.
5. Kozlov V. "The Fires of Winter." In AGING, ed. Goldstein, E.C., Vol. 2, Art. 35, Boca Raton, FL. Social Issues Resource Series, Inc. 1981.
6. Haney DQ. Altering Habits Can Lengthen Life. In AGING, Ed. Goldstein, E.C., Vol. 2, Art. 11, Boca Raton, FL. Social Issues Resource Series, Inc. 1981. ■

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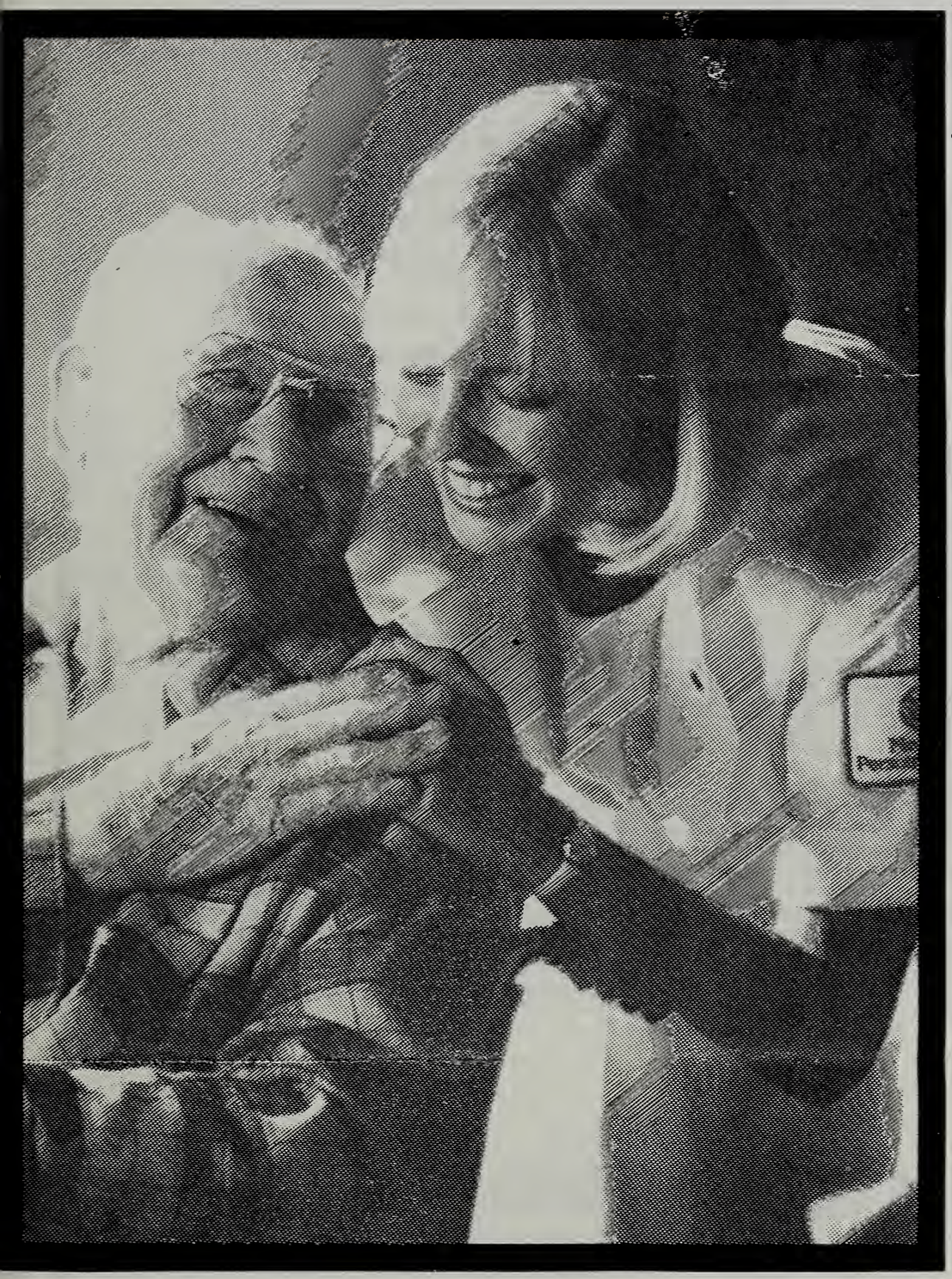

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Analysis of a Pediatric Death Suit: Negligence Occurred But Causation and the Jury Contribute to Defense Verdict

Robert J. Miller*

This article reviews the circumstances that brought about a defense verdict in the tragic death by botulism of a seven-week-old infant.

A medical malpractice lawsuit is rarely won once negligence has been established. But in this interesting case, the jury was capable of perceiving the difference between the negligent actions of the defendant physician and the death of the child. One was not caused by the other, the jury decided.

A healthy, full-term, male infant had weighed 5 lbs., 11 oz. at birth. Except for a mild staph infection in the third week of life, the baby had been healthy. At seven weeks of age the baby weighed 9 lbs.

At about this time the mother took the baby to one of the two physician defendants in this case, a board-certified pediatrician who will be referred to as Dr. A. The baby was listless and constipated, the mother said. He was also not taking the breast as he should. The doctor examined the baby and noted mild conjunctivitis. The doctor suspected "viremia" rather than a bacterial infection, but did order a CBC, just to be on the safe side. That afternoon the results of the CBC came back normal.

That same evening the mother brought the baby to the defendant hospital's Emergency Room where the same doctor once again examined the baby. He noted a slight discharge from the baby's left eye; color was good; chest clear; the baby was alert and responsive and did not seem in any distress. Dr. A concluded that the child was suffering from a mild upper respiratory infection.

The baby died over the weekend and Dr. A never saw the baby again but learned of the death from his partner when he returned from the weekend.

On the following day the baby was once again brought to the hospital, this time to be seen by the other pediatrician partner, Dr. B. Examination revealed that the baby was listless, pallid, had decreased skin turgor and had lost weight, down to 7 lbs., 14 ozs.

Dr. B made an initial diagnosis of viremia with dehydration. Treatment was initiated with Ampicillin and Gentamicin as well as fluid replacement. Later in the afternoon the infant became more listless and, at the point at which it was noted the baby no longer exhibited a gag reflex, a diagnosis of botulism was made.

At this point Dr. B decided to transfer the baby to a tertiary care unit. In preparation for this transfer the infant was intubated. Within ten minutes following the intubation the baby suffered bradycardia followed by respiratory arrest and could not be resuscitated.

The baby's parents eventually filed a lawsuit against both Drs. A and B and also named the treating hospital as a defendant. Dr. A was ultimately dropped

* Mr. Miller is vice president of Consumer Affairs and Risk Management for The Medical Protective Company of Fort Wayne, Indiana.

from the suit as was the hospital. Dr. B remained as the sole defendant.

Criticisms of the care provided to the deceased child were divided into two areas: proper assessment and treatment of the dehydration and the length of time it took to establish the diagnosis of botulism.

Expert witnesses were called to evaluate the rehydrating process with a majority stating that this procedure was conducted in a timely and proper manner. There was discussion about the length of time it took to establish a diagnosis of botulism (eventually confirmed by pathology report). Some of the nursing staff seemed to recall that Dr. B had mentioned the possibility of this diagnosis earlier in the day, while other nurses testified that it was not until late in the afternoon, when the child no longer exhibited a gag reflex, that the defendant pediatrician established botulism as the diagnosis.

Because of the confusion over *when* Dr. B actually established a firm diagnosis of botulism, and because the issue was not clear in the records, the jury decided that Dr. B had been negligent because he hadn't made the diagnosis soon enough.

With this affirmation of negligence by the jury, it could safely be assumed that the doctor would be required to pay an award to the plaintiff. But in this case, surprisingly, no such award was named by the jury and here's the reason why: the jury was sophisticated enough to be able to differentiate between causation and negligence. The defense was able to explain (and the jury was capable of understanding) that the care being given to this baby was proper and supportive for botulism and that, had the diagnosis occurred earlier, the child would still have died. Doctor B's failure to make the accurate diagnosis earlier *did not* contribute to the baby's death.

This was a rare decision because most juries assume that *if negligence occurred, then the doctor must be "guilty" and an award assessed to the plaintiff.* It is therefore interesting to take note of the composition of this particular jury.

The suit, which had originally been filed in a large metropolitan area in the eastern part of the United States was eventually referred back, by the court, to the largely suburban and rural area in which the service had actually occurred.

The jury was composed of the following individuals:

1. *# A computer scientist in his mid-40s whose wife worked for a psychiatrist.
2. *# An engineer who personally knew Dr. A as team physician for this juror's son's high school football team.
3. * A young man who lived in the area and who had once had knee surgery performed at the defendant hospital.
4. *# A man in his late 50s who works as an auditor for the department of defense and whose son is a defense attorney.
5. A young auto mechanic.
6. * A retiree who had worked at a nearby state hospital.
7. # A program manager in his late 40s.
8. A truck driver.
9. # A middle-aged manager of an accounting firm.
10. *# A well-educated woman in her late 50s, married to a physician.
11. # A young woman manager of sales and purchasing for a local retail store.
12. The youngest juror, in his early 20s, an employee of a local car dealership.

It is interesting to note that, just on a speculative basis, jurors identified with * might be likely to have positive feelings about medical care in general. It is also likely that jurors identified with # are college graduates. Did it take a jury with this kind of capacity to discern the difference between causation and negligence? Very likely.

In evaluating the final (and somewhat surprising) outcome of this interesting case, a territory manager for The Medical Protective Company analyzed the insurer's approach to the case. This attorney wrote: "... we often discount or limit our faith in the defense of causation or proximate cause and have sometimes been reluctant to take a case to trial when the conduct of the doctor has fairly well been established as substandard but may not have been the cause of the eventual outcome to the plaintiff."

"In this case, we had a very sophisticated and intelligent jury, which was properly instructed by the judge, and considered all of the elements of the case which the plaintiff had to provide, including the issue of whether the conduct of the doctor actually was a cause of the eventual outcome to the plaintiff." ■

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Arkansas HIV/AIDS Report 1983-1992

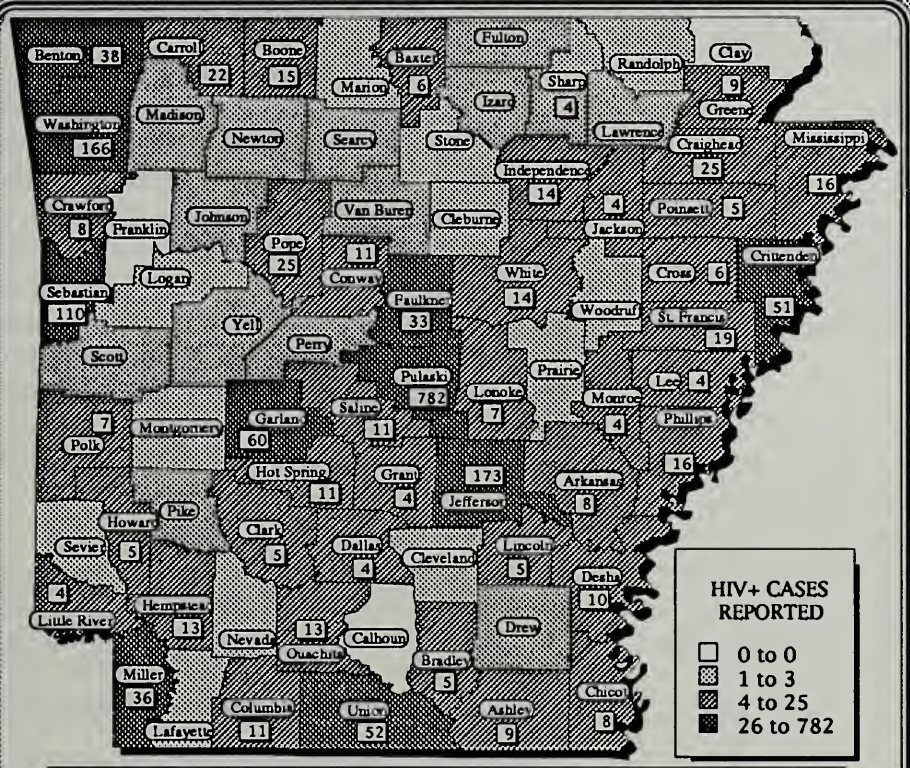
Arkansas: June 1983 through July 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	438	421	217	1,643	85.57
	Female	1	1	6	27	39	71	89	43	277	14.43
AGE	< 5	0	0	1	1	2	9	14	4	31	1.61
	5-12	0	0	0	1	1	5	2	0	9	0.47
	13-19	0	0	0	8	8	14	20	19	69	3.59
	20-29	8	10	15	109	125	192	153	97	709	36.93
	30-39	7	15	22	86	105	206	219	94	754	39.27
	40-49	4	7	11	24	35	61	73	30	245	12.76
	> 49	1	1	6	6	12	19	23	15	83	4.32
	Unknown	0	0	0	8	2	3	6	1	20	1.04
RACE	White	16	24	47	171	178	353	311	154	1,254	65.31
	Black	4	9	8	70	107	153	195	102	648	33.75
	Other	0	0	0	2	5	3	4	4	18	0.94
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	260	1,920	100%

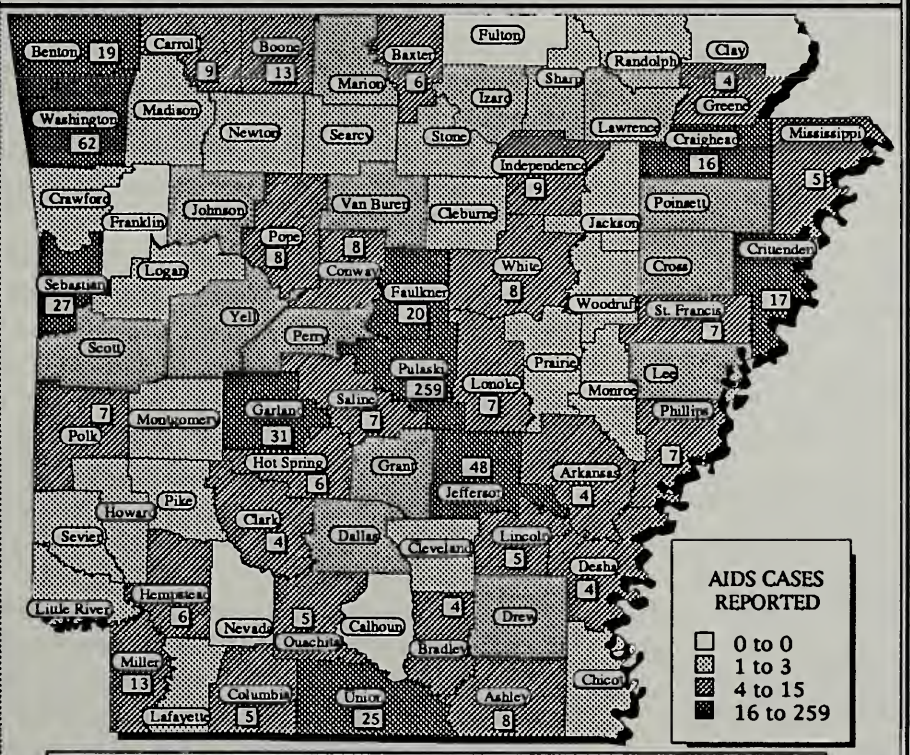
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	105	683	89.52
	Female	1	0	4	6	10	20	25	14	80	10.48
AGE	< 5	0	0	0	1	1	6	6	1	15	1.97
	5-12	0	0	0	1	0	1	1	0	3	0.39
	13-19	0	0	0	0	0	4	3	1	8	1.05
	20-29	7	9	15	27	24	55	57	34	228	29.88
	30-39	3	13	23	36	41	78	80	48	322	42.20
	40-49	1	6	8	10	7	35	41	23	131	17.17
	> 49	1	0	4	8	7	11	13	12	56	7.34
RACE	White	9	22	43	61	58	141	134	81	549	71.95
	Black	3	6	7	20	21	47	66	36	206	27.00
	Other	0	0	0	2	1	2	1	2	8	1.05
RISK	Male/Male Sex	7	17	31	59	50	118	118	68	468	61.34
	Injection Drug User (IDU)	0	2	10	4	11	18	28	14	87	11.40
	Male/Male Sex & IDU	3	9	4	6	6	18	17	7	70	9.17
	Heterosexual	2	0	2	3	6	10	10	9	42	5.50
	Transfusion	0	0	2	7	3	7	11	3	33	4.33
	Perinatal	0	0	0	1	1	6	6	1	15	1.97
	Hemophiliac	0	0	0	1	1	5	5	2	14	1.83
	Undetermined	0	0	1	2	2	8	6	15	34	4.46
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	119	763	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 1,920 Arkansans have been reported to be HIV+ as of July 25, 1992.



A total of 763 Arkansans have been diagnosed with AIDS as of July 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

ALMA

Schlabach, Ronald D., Family Practice. Born, 3/10/61. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1987. Residency, UAMS-AHEC, Fort Smith, 1990. Board certified.

CROSSETT

Grigsby, Benson A., Family Practice. Born, 1/14/54. Medical education, Louisiana State University Medical School, New Orleans, 1985. Internship/residency, The Medical Center, Columbus, GA, 1988. Board certified.

EL DORADO

Deere, Joy Lucretia, Psychiatry. Born, 3/2/34. Medical education, Baylor University College of Medicine, Houston, TX, 1959. Internship, Presbyterian St. Luke's Hospital, Chicago, IL, 1960. OB/GYN residency, Baylor University College of Medicine, Houston, TX, 1960; Psychiatry residency, University of Texas Medical School, Houston, 1991.

FORDYCE

Cunningham, James A., Family Practice. Born, 5/17/37. Medical education, St. Georges University, Grenada, West Indies, 1979. Internship, University of Kentucky, Lexington, 1981.

FORT SMITH

Hamilton, Lance L., Internal Medicine. Born, 8/28/62. Medical education, University of Oklahoma, Stillwater, 1984. Internship/residency, Kansas University Medical Center, 1991. Board eligible.

Marvel, Jeffrey B., Otolaryngology. Born, 8/26/61. Medical education, University of Texas, Houston, 1986. Internship/residency, Baylor College of Medicine, 1992.

Mehl, John K., Cardiovascular Disease. Born, 1/5/55. Medical education, Ohio State University College of Medicine, Columbus, 1982. Internship/residency, Ohio State University Hospital, 1985. Board certified.

Phillips, Tonya L., Neurology. Born, 9/25/61. Medical education, UAMS, 1988. Internship/residency, UAMS. Board eligible.

HARRISON

Casey, Rick E., OB/GYN. Born, 8/21/51. Medical education, UTMB, Galveston, 1976. Internship/residency, John Peter Smith Hospital, 1980. Board certified.

JONESBORO

Moseley II, Claiborne L., Orthopaedics. Born, 3/10/52. Medical education, University of South Carolina School of Medicine, Columbia, 1981. Internship, Naval Hospital, Pensacola, FL, 1981. Residency, Richland Memorial Hospital, Columbia, SC, 1990.

Woodward, Gary W., Otolaryngology. Born, 11/26/48. Medical education, McMaster University, Hamilton, Ontario, Canada, 1974. Internship, McMaster University Medical Centre & Affiliates, 1976. Residency, University of British Columbia at Vancouver General Hospital & Affiliates, 1979.

LITTLE ROCK

Aaland, Mary O., Surgery. Born, 7/11/56. Medical education, University of North Dakota, 1982. Internship, Jersey City Medical Center, NJ, 1983. Residency, University of Illinois, Peoria, 1988. Board certified.

Barnes, C. Lowry, Orthopaedic Surgery. Born, 4/26/60. Medical education, UAMS, 1986. Internship/residency, UAMS, 1991.

Carney, John M., Dermatology. Born, 12/5/52. Medical education, Northwestern, Chicago, IL, 1979. Internship, Butterworth Hospital, Grand Rapids, MI, 1980. Residency, University Hospital, Cleveland, OH, 1984 Board certified.

Graham, Charles J., Pediatric Emergency Medicine. Born, 10/7/59. Medical education, UAMS, 1985. Internship/residency, UAMS, 1988. Board certified.

Portilla, Maria G., Pediatrics. Born, 7/18/51. Medical education, Universidad del Valle, Cali, Columbia, South America, 1980. Internship, Tulane University School of Medicine/Charity Hospital, 1982. Residency, St. Louis University School of Medicine/Cardinal Glennon Children's Hospital, 1984. Board certified.

Schutze, Gordon E., Pediatrics-Infectious Diseases. Born, 4/10/58. Medical education, Texas Tech University Health Science Center, Lubbock, 1984. Internship/residency, Baylor College of Medicine, 1988. Fellowship, Baylor College of Medicine, 1991. Board certified.

Spencer, Julia R., Pediatric Urology. Born, 4/6/57. Medical education, Northwestern University,

Chicago, 1981. Internship/residency, Northwestern University, Chicago, 1988. Board eligible.

Stringer, Warren A., Radiology. Born, 9/26/54. Medical education, Loma Linda University, CA, 1980. Internship, Georgetown University Hospital, Washington, D.C., 1981. Residency, Georgetown/Loma Linda, 1987. Board certified, Radiology & Internal Medicine.

Sturner, William Q., Forensic Pathology. Born, 9/6/34. Medical education, St. Louis University, MO, 1959. Internship/residency, St. Louis University/University of London/University of Kentucky, 1964. Board certified, Anatomic, Forensic, Clinical.

Torres Jr., Adalberto, Pediatric Critical Care. Born, 12/19/59. Medical education, University of Illinois, Rockford, 1989. Residency, Loyola University Medical Center, 1989. Fellowship, Children's Hospital of Wisconsin, 1992.

Worley, Linda Lee M., Psychiatry. Born, 10/1/61. Medical education, Oklahoma University College of Medicine, 1988. Internship/residency, Oklahoma Teaching Hospitals, 1992. Board eligible.

MORRILTON

Lyon, Jack A., Family Practice. Born, 7/13/61. Medical education, UAMS, 1987. Residency, Fayetteville, 1990. Board certified.

MOUNTAIN HOME

Elders, John G., Family Practice. Born, 8/20/63. Medical education, UAMS, 1987. Internship/residency, Cox Medical Center, Springfield, MO, 1992. Pending certification.

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Evans, Clifford L., Radiation Oncology. Born, 6/28/39. Medical education, UAMS, 1964. Internship, St. Francis Hospital, Wichita, KS, 1965. Residency, University of Southern California, 1986. Board eligible.

ROGERS

Motta, Paul, Allergy Immunology. Born, 1/2/57. Medical education, New York College of Osteopathic Medicine, Old Westbury, 1983. Internship/residency, Keesler AFB Hospital, MS, 1986. Board certified, Pediatrics, Allergy & Immunology.

Ubben, Kenneth L., Dermatology. Born, 4/4/47. Medical education, University of Iowa, Iowa City, 1973. Internship, LaCrosse Lutheran Hospital, 1974. Residency, University of Minnesota, 1979. Board certified.

SHERWOOD

Chaffin, Raines A., Family Practice. Born, 1/14/60. Medical education, Kansas University School of Health Sciences, Kansas City, 1987. Residency, Floyd Medical Center, Rome, GA, 1990. Board certified.

VAN BUREN

Delk II, John R., Urology. Born, 11/4/53. Medical education, University of Texas Health Science Center, Houston, 1981. Internship/residency, Case Western Reserve University, Cleveland, OH, 1988. Board certified.

OUT-OF-STATE

Kronfol, Ned O., Nephrology/Internal Medicine, Greenville, MS. Born, 7/29/50. Medical education, American University of Beirut Medical School, Beirut, Lebanon, 1975. Internship/residency, American University of Beirut Medical School, Beirut, Lebanon, 1977. Board certified.

RESIDENT PHYSICIAN SECTION

Bates, William R. Born, 4/6/62. Medical education, Louisiana State University Medical Center, Shreveport, 1992. Residency, UAMS.

Beisel, Lisa J., Psychiatry. Born, 7/12/64. Medical education, University of Texas Medical Branch, Galveston, 1990. Internship/residency, UAMS.

Buckner, Mark B., Emergency Medicine. Born, 10/1/60. Medical education, Texas Tech University, Lubbock, 1991. Internship/residency, UAMS.

Carter, Charles C., Family Practice. Born, 9/5/43. Medical education, UTESA, Santo Domingo, Dominican Republic, 1991. Residency, AHEC, El Dorado.

Chain, Vicki S., Family Practice. Born, 8/24/49. Medical education,

Crocker, Micheal A., Anesthesia. Born, 1/29/65. Medical education, UAMS, 1991. Internship/residency, UAMS.

Dunaway, Joseph D., Family Practice. Born, 8/12/55. Medical education, , 1992.

Ekanem, Felix M. Family Practice. Born, 10/21/54. Medical education, UTESA, Santo Domingo, Dominican Republic, 1988.

Hope, Richard, Dermatology. Born, 9/6/63. Medical education, 1991.

Hunt, Randall E., Family Practice. Born, 10/3/52. Medical education, , 1990.

Julka, Sudhir K., Internal Medicine/Nephrology. Born, 3/20/55. Medical education, Maulana Azad Medical College, New Delhi, India, 1980. Internship, Maulana Azad Medical College. Residency, Prince Georges General Hospital, MD. Fellowship, UAMS.

Lindstrom, Philip R., Family Practice. Born, 1/16/57. Medical education, College of Osteopathic Medicine of Pacific, Pomona, CA, 1992. Internship/residency, UAMS.

Masterson, Robert C., Family Practice. Born, 7/20/66. Medical education, , 1992.

McAlister, Robin J. Family Practice. Born, 4/23/62. Medical education, UAMS, 1990. Internship/residency, AHEC-NW, Fayetteville.

Nichol, Brian T. Anesthesiology. Born, 4/22/64. Medical education, UAMS, 1991. Internship/residency, UAMS.

Ramdat, Kenneth C. Born, 6/20/55. Medical education, Spartan Health Sciences University, Vieux Fort St. Lucia, 1987.

Saidi, Johnaqa. Family Practice. Born, 3/21/49. Medical education, Kabul University Faculty of Medicine, Jalalabad, Afghanistan, 1974. Internship/residency, Kansas University Medical Center, Kansas City.

Schmitz, James, Family Practice. Born, 9/26/64. Medical education, , 1992.

Scott, A. DeMarques, Emergency Medicine. Born, 8/22/64. Medical education, University of Kansas Medical Center, Kansas City, 1991. Internship/residency, UAMS.

Thomas, Joanna M., Family Practice. Born, 3/27/60. Medical education, University of Liverpool, England, 1984. Internship, Royal Liverpool Hospital, England, 1985.

ZeBranek, James D. Osteopathy. Born, 6/2/55. Medical education, Michigan State University, E. Lansing, 1984. Internship, Florida Hospital of St. Petersburg. Residency, University of Cincinnati, OH.

MEDICAL STUDENTS

Anderson, Patric N.
Blake, Jeremy T.
Brown, Robert D.
Brownfield, Shannon
Calhoun, Aris
Chi, Jasen C.
Cox, Kerry D.
Dagger, Joseph S.
Douglas, Donald S.
Frankowski, Gary
Graham, Tonya
Hardin, Christopher
Hart, Susan K.
Hinton III, Johnnie
Hixson, Gayle
Irvin, John D.
Jenkins, Brad
Locke, Stephen
Merchant, Rhonda J.
Ritenour, Anita R.
Robinson, Mark T.
Rohlman, Teresa
Stotler, Michael B.
Stroud, Holly
Tai, Elizabeth I.
Whiteside, Thomas F.
Whytsell, Tina K.
Wilson, Amy C.

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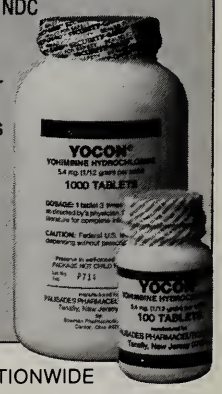
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Radiological Case of the Month

David L. Harshfield, M.D.
Kelly Grigg
Kyle Roper
Marianne Anthony, M.D.
Kevin F. Forte, M.D.

History:

The patient presented to his primary care physician with a history of chronic abdominal pain and weight loss. The past medical history was positive for previous episodes of Peptic Ulcer disease and elevated Amylase reportedly due to the patient's alcoholism. The presenting laboratory screen demonstrated abnormal liver functions (with an obstructive pattern) in addition to an elevated Amylase.

Figure 1. The medial border of the duodenum is displaced laterally (arrows) while the ampulla maintains its normal anatomic position (arrow head) creating a "reversed E" appearance.

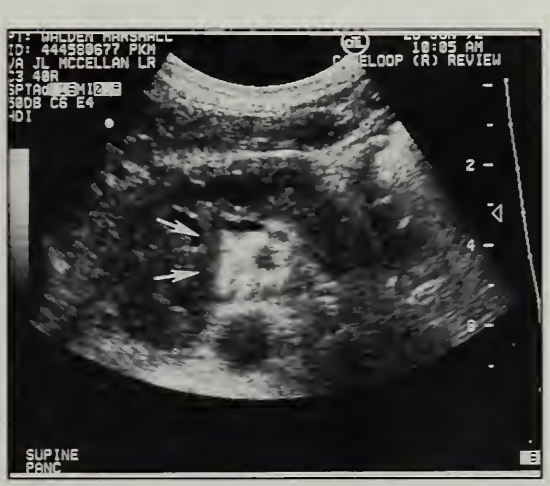

Figure 2. The abdominal ultrasound reveals an enlarged pancreatic head (arrows).

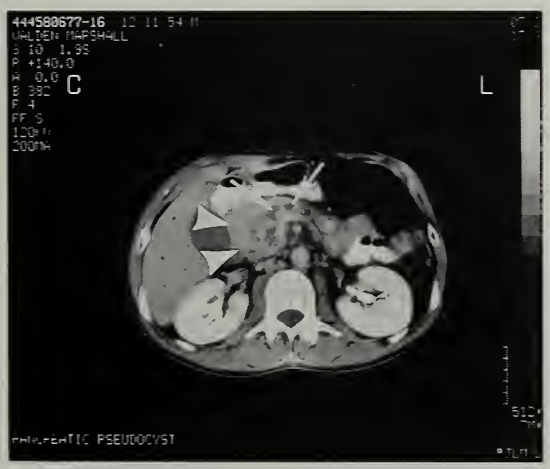

Figure 3. Axial CT cut reveals the pancreatic head mass (arrow headss) and dilated pancreatic duct (arrows).

Figure 4. The intraoperative cholangiogram reveals the dilated intrahepatic bile ducts and the abrupt but smooth extrinsic mass effect of the distal common bile duct (arrows) as it passes through the pancreatic head mass.

Pancreatic Head Carcinoma

Findings:

The upper GI revealed a normal mucosal fold pattern with a "reversed E" appearance of the duodenal C-loop, raising a suspicion for pancreatic head mass (figure 1). The "backward E" is formed when the pancreatic mass pushes the duodenum laterally while the ampulla of vater is tethered medially. Ultrasound examination revealed in addition to gallstones, an enlarged pancreatic head with an associated pancreatic duct dilatation (figure 2). The abdominal CT transverse image corroborated these findings and further characterized the pancreatic head mass and evidence of pancreatic duct and intrahepatic biliary dilatation as well (figure 3). The patient underwent surgery to correct his biliary obstruction. The intraoperative cholangiogram revealed narrowing of the common bile duct and dilatation of intrahepatic biliary structures (figure 4). The patient underwent a choledochojejunostomy after the frozen sections were returned and revealed pancreatic head carcinoma.

Discussion:

Although pancreatic head cancer comprises only 4% of the Gastrointestinal carcinomas, this represents the second most common malignancy of the GI tract. Colon cancer represents well over 90% of all GI malignancies. Unfortunately, unless discovered "accidently," pancreatic carcinoma does not present until late in the course of the disease. Because of its retroperitoneal position, pancreatic pathology may remain "silent" until the disease is extensive. The point to be made is, any diagnostic study of the abdomen should assess the pancreas within the limitations of the exam, itself and the body habitus of the patient. This patient has multiple imaging studies, all of which confirm the diagnosis of a pancreatic head mass. The upper GI study, which was performed for peptic ulcer disease, serendipitously revealed the pancreatic head enlargement. The ultrasound examination performed for obstructive jaundice discovered not only the dilated biliary tree but also revealed the enlarged pancreatic head and dilated pancreatic duct as well. The CT examination is the most sensitive and specific diagnostic tool for pancreatic disease.

In this patient, there was a focal enlargement of the head of the pancreas and a diffuse enlargement of the remainder of the pancreas. In general, pancreatic carcinoma is a focal lesion, however, when the mass is localized to the head of the pancreas, the remainder of the pancreas may enlarge related to pancreatic duct obstruction and associated pancreatitis. Although a diffusely enlarged organ is thought to occur more commonly secondary to inflammation (pancreatitis), a carcinoma may also present in this manner. This patient underwent a Whipple procedure, which is considered paliative. In selected cases, these patients can have stents or external drainage to allow biliary decompression and forego the debilitating surgical procedure from which they may not recover before they succumb to their disease.

Editor: *David Harshfield, M.D., is chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.*

Contributor: *Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.*

Contributor: *Kyle Roper is a senior medical student at the University of Arkansas for Medical Sciences in Little Rock.*

Contributor: *Marianne Anthony, M.D., is affiliated with the Veterans Administration Hospital in Little Rock.*

Contributor: *Kevin F. Forte, M.D., is affiliated with the Veterans Administration Hospital in Little Rock.*

AMS Newsmakers

Dr. Brad Baltz, a resident in the Department of Hematology/Oncology at the University of Arkansas for Medical Sciences, was chosen to receive an American Cancer Society Clinical Oncology Fellowship in the amount of $10,000.

The grant will enable Dr. Baltz to participate in a six-month research project at the Arkansas Cancer Research Center about Natural Killer (NK) cell function.

Fellowship grants such as this are awarded annually to institutions to improve the management of cancer patients by supporting clinical oncology training for young physicians.

Dr. Owen H. Clopton Jr., of Internal Medicine Associates of Jonesboro, was elected to serve on the board of directors for the American Lung Association of Arkansas.

Dr. James Cook, an emergency room physician at Baxter County Regional Hospital in Mountain Home, was honored by the Arkansas Affiliate of the American Heart Association for his volunteer work with the association.

Dr. Cook received one of the highest volunteer recognition awards, an affiliate-supported cardiovascular research project named the Jim Cook, M.D. Research Project.

Dr. R.C. Goodman Sr., a retired anesthesiologist from Fort Smith, was honored recently when Sparks Regional Medical Center officials dedicated the R.C. Goodman Institute for Pain Management. It is in the Sparks Ambulatory Surgery Center.

Dr. Fred C. Inman Jr., of Carlisle, has retired after 40 years in general practice as a family physician. Congratulations!

Dr. Charles R. Klepper, an internist from Harrison, has received certification as a diplomate in geriatric medicine from the American Board of Internal Medicine.

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicains who have completed acceptable programs of continuing education. The recipients for the month of July are:

David B. Fraser	El Dorado
Diane G. Lepore	Jonesboro
James E. McDonald	Little Rock
Kevin L. Pope	Fayetteville
Douglas E. Young	Little Rock

ORTHOPAEDIC RESEARCH AND EDUCATION FOUNDATION

The members of the Order of Merit set the example for their colleagues, orthopaedic industry and the public. They demonstrate the power of philantrhopy in expanding knowledge in orthopaedics for the relief of human suffering. Following is the Arkansas Roster of the 1991 Members, including all orthopaedists from Pine Bluff which has, thereby, been designated a "City of Merit."

- Banks Blackwell, M.D., Medical Director -

James A. Arnold, M.D., Fayetteville
Mr. Michael M. Bailey, Little Rock
Banks Blackwell, M.D., Pine Bluff
(A Memorial Tribute to Lyman Smith, M.D.)
Charles A. Clark, M.D., Pine Bluff
Robert R. Gullett, Jr., M.D., Pine Bluff
(A Memorial Tribute to Richard LeBlanc, M.D.)
Dr. & Mrs. Peter J. Irwin, Fort Smith
Philip H. Johnson, M.D., Little Rock
Dr. & Mrs. James M. Kolb, Jr., Russellville
Dr. & Mrs. Charles A. Ledbetter, Harrison
(A Tribute to Donald B. Kettelkamp, M.D.)
John O. Lytle, M.D., Pine Bluff
Dr. & Mrs. Bruce L. Smith, Jr., Hot Springs
J. L. Vander Schilden, M.D., Little Rock
(A Memorial Tribute to Richard Webber, Ph.D.)

In Memoriam

Jeff J. Baggett, M.D.

Dr. Jeff J. Baggett, a retired physician from Prairie Grove, died Thursday, July 16, 1992. He was 85.

Dr. Baggett was a Life member of the Arkansas Medical Society and a member of the Fifty Year Club. He was also a member of the American Medical Association, the Washington County Medical Society, and the American College of Surgeons.

Survivors are his wife, Frances Gose Baggett of Prairie Grove; three daughters, Sandra Long of Golden, Colo., Judy Lytton of Cookson, Okla., and Karol Zoeller of Little Rock; seven grandchildren; and, four great-grandchildren.

Mrs. Elizabeth Caplinger

Mrs. Elizabeth Ann Owens Caplinger, wife of Dr. Kelsy Caplinger, died Monday, July 27, 1992. She was 54.

Mrs. Caplinger was a member of the Arkansas Medical Society Auxiliary and worked as a bookkeeper at the Little Rock Allergy Clinic.

Other survivors are a son, Jeffrey Jenkins Caplinger of North Little Rock; a daughter, Jennifer Caplinger Rose of New York; her mother, Jewel Owens of Little Rock; and two brothers, Thurman Owens Jr. of Memphis and Leslie Owens of Benton.

Lawrence E. Drewrey, M.D.

Dr. Lawrence Eudell Drewrey, a retired physician from Camden, died Monday, July 13, 1992. He was 82.

Dr. Drewrey was a member of the Arkansas Medical Society.

He is survived by his wife, Mary Baker Drewrey of Camden; two daughters, Mary Margaret Broach of Knoxville, Tenn., and Joan Morton of Little Rock; three sisters; and two grandchildren.

Laurence G. Fincher Sr., M.D.

Dr. Laurence G. Fincher Sr., a retired physician from El Dorado, died Thursday, July 16, 1992. He was 94.

Dr. Fincher was a member of the Arkansas Medical Society.

He is survived by two sons, Dr. L.G. Fincher Jr. of El Dorado and Edward Raley Fincher of Little Rock; one daughter, Kay Fincher Hyland of Dallas; one sister, Marjorie Fulmer of Little Rock; seven grandchildren; and six great-grandchildren.

James S. Mize, M.D.

Dr. James Samuel Mize, a general surgeon from Pocahontas, died June 24, 1992. He was 56.

Dr. Mize was a member of the American Medical Association, the Arkansas Medical Society, and the Randolph County Medical Society.

He is survived by his wife, Barbara Fry Mize of Pocahontas; two sons, David Mize of Denver, Colo., and Thomas Mize of Pocahontas; a daughter, Ann Mize of Denver, Colo.; his mother, Mrs. Mavis Mize of Pocahontas; and a brother, Robert Mize of Denver, Colo.

Henry M. Sims, M.D.

Dr. Henry Mitchell Sims, a retired physician from North Little Rock, died Saturday, August 8, 1992. He was 74.

Dr. Sims was a former member of the American Medical Association, the Arkansas Medical Society, and the Pulaski County Medical Society.

He is survived by a son, Paul Anthony Sims of Dallas; four daughters, Carol Ann Wineland of Germantown, Tenn., Norma Sims Meadors of Fort Smith, Elaine K. Childers of Midwest City, Okla., and Barbara Sims Johnson of Memmphis; a sister, Mrs. W.J. Stewart of Siloam Springs; and seven grandchildren.

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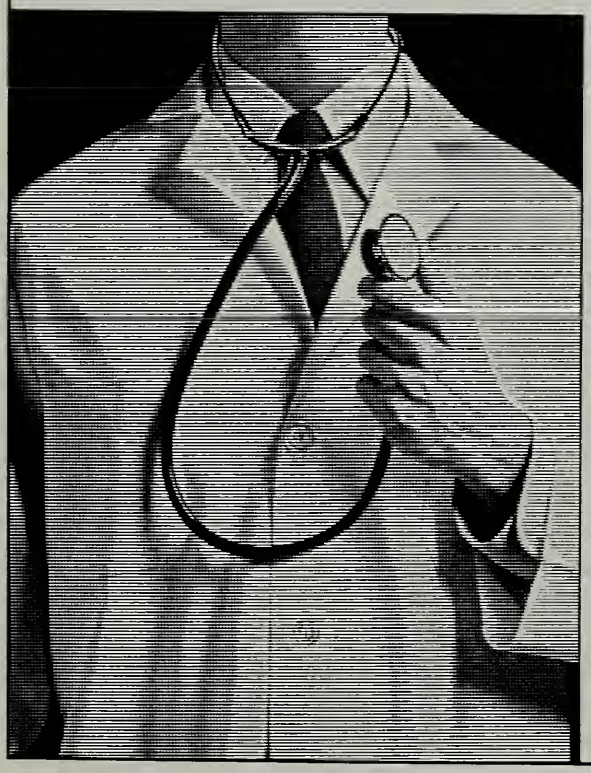

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Medicine in the News

Auxiliary Changes Name

"Historic," was the word American Medical Association Auxiliary President Sherry Strebel used to describe the action taken by the 1992 House of Delegates of the AMAA when a majority of delegates voted to alter the name of the organization to American Medical Association Alliance and to add the tag line, "Physicians' spouses dedicated to the health of America."

The name change passed by a vote of 229 for and 88 against. The change won't be official until June, 1993. Individual states and counties must decide if they wish to conform to the change or keep the title auxiliary for their groups.

The organization had the name change researched before presenting it to component auxiliaries, and researchers supported the idea that the term "alliance" would project a more positive, progressive image of the group.

The national organization will be celebrating its 70th year this year, so the name change truly is historic.

Arkansas was represented at the American Medical Association Auxiliary Convention in Chicago, June 20-24, by the delegation below: (standing left to right) Michelle Rogers (David), Fayetteville; Barbara Moody (Michael), Salem; Peyton Bishop (William), Little Rock; Sandy Harrison (William), Little Rock; (seated left to right) Arleta Power (Robert), Little Rock; Rita Rodgers (Charles), Little Rock; and Liz Riley (William), Little Rock.

Arkansas Delegation to the AMA Auxiliary Convention

Health Care Access Foundation Update

As of July 1992, the Arkansas Health Care Access Foundation has provided free medical service to 4,407 medically indigent persons, received 9,423 applications, and enrolled 19,768 persons.

The program has 1,504 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 62 of the 75 counties.

State Medical Board Minutes

The Arkansas State Medical Board met March 12-13, 1992. Actions and a summary of that meeting follows:

- Dr. David Jacks, Pine Bluff, was welcomed to the board. His term began January 1, 1992 and will expire December 31, 1999.

- A public hearing to consider a resolution designating examinations as appropriate for licensure for physicians making application to practice in the State of Arkansas, was held on March 12, 1992. The Board voted to adopt the National Board of Osteopathic Medical Exam, Federation Licensing Exam, United States Medical Licensing Exam, National Board of Medical Exam, and Le Medical Counsel of Canada.

- Dr. Denise Hollabaugh appeared before the Board in answer to an Order and Notice of Hearing pursuant to Arkansas Code Ann. Sub. Sec. 25-15-201 et seq., of the Administrative Procedure Act and Arkansas Code Ann. Sub. Sec. 17-93-410 of the Medical Practices Act, charging alleged violation of Arkansas Cod Ann. 17-93-409 (7), grossly negligent or ignorant malpractice, by the violating of Regulations 4(4), in the prescribing of excessive amounts of controlled substances to various prescriptions for an addictive or potentially harmful drug to said patient. Dr. Hollabaugh's license was placed on probation status for one year; that she be required to obtain 50 hours continuing medical education said period on subjects to include headache pain and pain management; that she refrain from writing Schedule II and III narcotic prescriptions for her patients or administering the same; that she

submit to periodic monitoring by investigators of the Arkansas State Pharmacy Board; and that she obey the laws of the State of Arkansas; more specifically, the Medical Practices Act and the Rules and Regulations of the Arkansas State Medical Board.

- Dr. Joe Martindale, director of the Arkansas Medical Society Physicians' Health Committee summarized to the Board, the Committee actions for the previous year and expressed his appreciation to the Board for its work and continued support.

- Licenses to practice were issued to 84 physicians. Drs. James A. Cunningham and Earl Dean Bray were issued temporary permits until information received by the Board could be investigated. Dr. Joseph A. Cook was issued a temporary permit until he submitted two letters of recommendation. Dr. Moises Barros Tuason Jr. was granted a temporary permit to do a fellowship at UAMS. Fifty temporary permits were issued to physicians who have permanent applications in process.

- Drs. Michael Young and Charles Vermont were approved for dispensing physician's license until a pharmacist moves into the area.

- The Board voted that people applying for their license by reciprocity and having no other problem, would not have to personally appear before the Board.

- The Board reviewed 25 complaints made against individual physicians. Thirteen matters for discussion were reviewed.

The Arkansas State Medical Board met June 11-12, 1992. Actions and a summary of that meeting follows:

- Dr. John E. Bell of Searcy was welcomed to the Board. His term begins in 1992 and will expire in 2000.

- Dr. and Mrs. John Guenthner were special guests of the Board.

- There were six Order to Show Cause hearings held: Dr. Michael Langley was found to be in violation of Arkansas Code Ann. Sec. 17-93-409(7), grossly negligent or ignorant malpractice by violating Rule and Regulation No. 2(4) in the prescribing of excessive amounts of controlled substances to various patients and the writing of an excessive number of prescriptions for addictive or potentially harmful drugs. Dr. Langley's license to the Board practice medicine in the State of Arkansas was suspended for a period of 30 days, he was to surrender his DEA license to the Board and not utilize privileges under the DEA license for a period of one year, he was placed on probation for a period of one year and within that year was to provide proof of attendance of continuing medical education in the field of pharmacology and pain management.

- Dr. Robert Thomas Clark appeared and was found in violation of Arkansas Code Ann. Sec. 17-93-409(5), violating the laws in regulating the possession and distribution and use of narcotic or controlled drugs classified in Schedules I-V of the Control Substances Act, and violated Sec. 17-93-409(10) by becoming physically or mentally incompetent to practice medicine to such probation for one year; that he surrender his license DEA to the Board and refrain from using any of the privileges of said license for the period of probation; that he participate in counseling with the Impaired Physicians Group of the AMS and comply with their Rules and Regulations, the Medical Practices Act, and the Rules and Regulations of the Arkansas State Medical Board.

- Dr. Charles W. Turner, was found to have violated Arkansas Code Ann. Sec. 17-93-409(7), grossly negligent or ignorant malpractice; that his emergency suspension be lifted and that we be granted a temporary permit to be review and automatically expire if not reissued at each upcoming meeting. Dr. Turner was placed on probation for one year and will take the Specialty Exam of the Federation, successfully pass it and provide the results to the Board with the next 12 months; and refrain from practicing OB/GYN and delivering children during the next year.

- Dr. Francis Marion Henderson was found to have violated Arkansas Code Ann. Sec. 17-93-409(3), aiding or abetting an unlicensed person to practice medicine. Dr. Henderson will be observed by the Board and/or its investigators for a period of one year; that he will no longer permit testing for patients without himself or another physician seeing said patient and incorporate said policy into his practice; that he refrain from all participation in Lifestyle and Vascular Center of Pine Bluff.

- Dr. Neema Garst appeared in answer to a Show

Cause Order. After testimony and discussion, the Board found there had been a violation of the Medical Practices Act, more specifically Arkansas Code Ann. Sec. 17-93-409(7), that is grossly negligent or ignorant malpractice. Dr. Garst's license to practice medicine in the State of Arkansas was suspended for a period of 30 days, then placed on probation for a period of one year wherein she will attend and successfully complete continuing medical education in the field of fertility, contraception and reproductive endocrinology, peer review and medical record keeping and provide proof to the Board.

- Dr. James Frederick Thomas Jr. appeared at the invitation of the Board. After discussion and testimony, the Board moved that the suspension of Dr. Thomas' license be continued until Dr. Thomas can attend a course of evaluation which would be outlined by the Physicians' Health Committee.

- Dr. John Hosea Young appeared before the Board in answer to a Show Cause Order. After thorough discussion, Dr. Zini moved there was a violation of the Medical Practice Act, more specifically, Arkansas Code Ann. Sec. 17-93-409(10), in that he became physically and mentally incompetent to practice medicine to such as extent as to endanger the public. Dr. Young's license to practice medicine in the State of Arkansas was placed on probation for a one year period wherein he will undergo psychiatric and/or psychological counseling and report said results to the Board; that he will appear personally every six months, and that he will execute a release form and authorize the board to acquire his medical, psychological and psychiatric records for review by the Board to determine his ongoing competency to practice medicine.

- Dr. James A. Cunningham will continue with a temporary permit until the next meeting to allow an ongoing review of Dr. Cunningham's hospital admissions.

- Ms. Cryer updated the Board on the number of licenses being issued by the Board. In 1990, there were 234, 273 in 1991, and from January until this time, six months, 226 have been licensed. This report indicates the tremendous workload of this office during the past six months, approximately twice the amount of work.

- Dr. Jouett announced to the Board that the staff would be doing a follow-up on physicians who say they are becoming American citizens in that it is incumbent to confirm who has followed through with their intent and who has not. If they have not, the Board will bring them back and revoke their license for not meeting the criteria for licensure.

- Dr. Jouett announced the 1993 meeting dates as March 11-12, June 10-11, September 16-17, and December 2-3.

- Dr. Clement John Lewis was denied licensure. Charles William Bosch, D.O., was denied license until he could clear his problems in Georgia and all restrictions were removed.

- Drs. David L. Brown, Gary R. Goza, Virgil Wooten and Robert Galbraith appeared as sleep disorder specialists, requesting authority to use Class II medications. This was approved and the Board voted that in the future all applications must be completed and a personal appearance before the Board by the physicians who would also like this privilege must be fulfilled before the Board will grant this privilege.

- One Order to Show Cause was issued for our September 17th meeting.

- Dr. Bell was asked to review venipuncture information and make a recommendation of action for the Board to consider at its next meeting.

- The Board reviewed 45 complaints made against individual physicians which were received for information only or a letter of reprimand was written.

- Licenses to practice were issued to 133 physicians. Eighteen temporary permits were issued.

The Board adjourned until September 17-18, 1992.

Doctors Hospital Completes Construction

Doctors Hospital in Little Rock recently opened their new 18-bed Outpatient Services Department. The opening of the outpatient area marks the end of Phase I in Doctors Hospital's expansion project. Other areas in the new building include the new patient registration and waiting area, an 18-bed recovery room, an outpatient mammography screening room, and inpatient/outpatient procedure ares for lab, X-ray and EKG.

Phase II, which will include the new four-room hand and microsurgery suite, is scheduled for completion by the end of 1992.

AIDS Patients and Discrimination

To identify physicians' experiences, attitudes and practices regarding human immunodeficiency virus (HIV) infected patients, the North Carolina Medical Society (NCMS) conducted a statewide survey, the results of which would be used to design medical education programs. In a article authored by Morris Weinberger, Ph.D., et al,. of the VA Medical Center in Durham, North Carolina and published in the July 1992 issue of the Southern Medical Journal, the survey results found that approximately 40% of the physicians surveyed reported refusing or referring HIV-infected patients whenever possible. Only half of the primary care physicians surveyed took sexual histories from new patients or provided patients with education material o AIDS. Respondents, especially surgeons and emergency room physicians, commonly reported concern that they or their staff might become infected. The survey found that physicians' concerns about HIV-infection reported nearly a decade ago still persist. Moreover, recommended practices are not being conducted routinely. Importantly, most physicians expressed a desire for educational programs to improve their competency in dealing with AIDS patients. However, educational programs alone may be insufficient to change physicians' behavior and further steps may be necessary for change. As a result of the survey, the NCMS instituted a program that supplements traditional mailed educational materials with a hands-on training programs for community physicians.

Friendship Bridge

Lecturing for two weeks in Hanoi and Saigon to Vietnamese physicians and other health care professionals may not have been one of the options you considered in your travel plans, but Dr. Theodore C. Ning Jr. thinks it should be.

Dr. Ning, a Colorado urologist, is founder of Friendship Bridge, a non-profit American organization that sends volunteer teams of physicians and other health care professionals from the United States to Vietnam for two weeks to teach and lecture at selected hospitals. The volunteers pay their own expenses for the period. "Vietnam is one of the poorest and saddest countries in the world," Dr. Ning said, "and its health care facilities are barely functioning. They lack everything. Their only asset is a dedicated and surprisingly well trained professional staff. These are the men and women with whom we work, trying to build on their initial training and bringing them current as well as helping to supply them with medications and equipment for their hospitals." All instruction is in English. Dr. Ning said Friendship Bridge can probably find a place for every American health care professional who volunteers for the two-week service since the need is so great.

Friendship Bridge also arranges and pays for Vietnamese health professionals to come to the U.S. for additional training and nearly a dozen have arrived in the Denver area. Often these professional visits turn into deeply moving experiences. One Hanoi cardiologist was reunited with her brother after a 37-year separation.

A third key service of Friendship Bridge is shipping donated or purchased medical supplies and equipment to Vietnam. Within the last two years, Friendship Bridge has sent over 76 tons of supplies and equipment to six teaching hospitals in Saigon and Hanoi.

If you wish to become a volunteer, contact Dr. Theodore C. Ning Jr., Friendship Bridge, 33424 Deep Forest Road, Evergreen, Colorado 80439 or call (303) 674-0717.

For more information, write to:
National Council on Patient Information and Education (NCPIE)
666 Eleventh Street, NW Suite 810 D
Washington, DC 20001

To fax your request — (202) 638-0773

Things To Come

September 18-20

3rd Midwest Regional Conference on Women in Medicine: The Heart of the Matter. Hyatt Regency Crown Center Hotel, Kansas City, MO. Sponsored by the University of Kansas Medical Center. AMA Category I and American Academy of Family Physicians credit hours available. Fees: $135.00, physicians; $60.00, fellows and residents; $115 other professionals; $40, full-time students. For more information, call Mary Boyd at (913) 588-4488.

September 24

Nursing Management Certificate Program. Sponsored by and held at the San Jose State University, Department of Continuing Education. For more information, call (408) 924-2601 or (408) 924-2600.

September 25

Update on Current Management Strategies for Chronic Granulocytic Leukemia. Westin Crown Center Hotel, Kansas City, MO. Sponsored by the University of Kansas Medical Center, Department of Internal Medicine, Division of Hematology and Bone Marrow Transplantation Section. AMA Category I credit hours available. For more information, call Mary Boyd at (913) 588-4488.

October 2

Treating the Addicted Patient in Primary Care Medicine: Smoking, Alcoholism and Drug Abuse. Battenfeld Auditorium, University of Kansas Medical Center, Kansas City, MO. Sponsored by the University of Kansas Medical Center, Department of Family Practice. AMA Category I and American Academy of Family Physicians credit hours available. Fees: $50.00, physicians; $25.00, KU faculty/staff; $15 residents/students. For more information, call Mary Boyd at (913) 588-4488.

October 3

Ultrasound Update. Red Lion Inn, Sacramento, CA. Sponsored by the Department of Radiology and the Office of Continuing Medical Education, University of California, Davis, School of Medicine and the Sacramento Radiology Research and Education Foundation, Northern California Radiology Society. AMA Category I and Society of Diagnostic Medical Sonographers credit hours available. Fees: $225.00, physicians; $180.00, technologist/residents. For more information, call (916) 734-5390.

October 8-9

Depression: Phenomenology, Etiology and Treatment. Sponsored by and held at the Laureate Psychiatric Clinic and Hospital, Tulsa, OK. Fees: $75.00, day; $150.00, conference. For more information, call 1-800-322-5173, ext. 4094.

October 10

Child and Adolescent Psychiatry Update. Rieke Auditorium, University of Kansas Medical Center, Kansas City, MO. Sponsored by the University of Kansas Medical Center. AMA Category I, American Academy of Family Physicians, American Nurses Association, and Social Workers credit hours available. Fees: $90.00, physicians; $50.00, clergy, nurses, psychologists, social workers; $35.00; KU faculty/staff, residents, full-time students. For more information, call Mary Boyd at (913) 588-4488.

October 13-14

28th Annual Postgraduate Symposium on Medicine and Religion. Battenfeld Auditorium, University of Kansas Medical Center, Kansas City, MO. Sponsored by the Department of the History and Philosophy of Medicine; Department of Social Services; Office of Continuing Nursing Education, and the Office of Continuing Education, University of Kansas Medical Center. AMA Category I, American Academy of Family Physicians, American Nurses Association, American Psychological Association, and Social Workers credit hours available. For more information, call Mary Boyd at (913) 588-4488.

October 16-17

Repetitive Injuries in the Workplace. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. Fees: $375.00. For more information, contact the Continuing Medical Education Department at 800-325-9862.

October 26-29

Primary Care Update. Riviera Hotel and Casino, Las Vegas, NV. Sponsored by Interstate Postgraduate Medical Association of North America. CME Category I credit hours available. Fees: $225.00, registration before October 1; $275.00, registration between October 1-21; $325.00, registration after October 21; $50.00, residents, interns, allied health professionals. For more information, call (608) 257-1401.

October 30

3rd Annual Rush Symposium on Hepatic and Biliary Disease. Sponsored by and held at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL. For more information, call Suzanne Buss at (312) 942-6242.

October 31

Recognition and Management of Parkinson's Disease for the Primary Care Physician. Holiday Inn Crowne Plaza, Kansas City, MO. Sponsored by the Department of Neurology, University of Kansas Medical Center. AMA Category I and American Academy of Family Physicians credit hours available. Fees: $40.00, physicians; $25.00, residents/full-time students. For more information, call Mary Boyd at (913) 588-4488.

November 5-8

ISACB 3rd Biennial Meeting: Toward Application of Advances in Basic Cardiovascular Biology. Adam's Mark Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine, Office of Continuing Medical Education, St. Louis, MO. For more information, call Cathy Caruso at 800-325-9862.

November 6-8

4th Annual Infectious Disease Review. Crowne Plaza Hotel, Rockville, MD. Sponsored by the Clinical Center of the National Institutes of Health. CME Category I credits available. For more information, call Svetlana Lisanti at 1-800-231-0389.

November 8-12

96th Annual Meeting of the American Academy of Ophthalmology. Dallas Convention Center, TX. For more information, call (415) 561-8500.

November 12-15

Southern Medical Association's 86th Annual Scientific Assembly. Registration information will be forthcoming. For more information, call 800-423-4992.

November 19

Practice Review and Update of Infectious Disease. Allis Plaza Hotel, Kansas City, MO. Sponsored by the Department of Internal Medicine, Division of Infectious Disease, University of Kansas Medical Center. AMA Category I, American Academy of Family Physicians, and American Nurses Association credit hours available. For more information, call Mary Boyd at (913) 588-4488.

November 20-21

Hyperlipidemia. Sponsored by and held at the University of California, Davis, Medical Center, Office of Continuing Medical Education, Sacramento, CA. CME Category I credits available. For more information, call (916) 734-5390.

November 21

Hyperlipidemia. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine, Office of Continuing Medical Education, St. Louis, MO. For more information, call Cathy Caruso at 800-325-9862.

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Keeping Up

Advanced Trauma Life Support Course

September 12-13, Saturday, 8:00 a.m. - 7:00 p.m., Sunday, 8:00 a.m. - 3:30 p.m., UAMS Education II Building, Little Rock. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $575.00. For more information, contact Cindy Reid at (501) 686-5261.

Nutrition and Aging VIII

September 16-17, 8:00 a.m., Excelsior Hotel, Little Rock. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $160.00. For more information, contact Cindy Reid at (501) 686-5261.

Advanced Cardiac Life Support

October 8, 9, 22, 23, 8:00 a.m., Russellville. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $150.00. For more information, contact Cindy Reid at (501) 686-5261.

Orthopaedic Surgery and the Athlete/ Arkansas Orthopaedic Alumni

October 9-10, 8:00 a.m., UAMS Education II Building, Little Rock. Sponsored by the UAMS College of Medicine CME Category I credit available. For more information, contact Cindy Reid at (501) 686-5261.

3rd Annual Physicians Update Weekend

October 10, 7:15 a.m. - 3:15 p.m., Center for Health Education, St. Vincent Infirmary Medical Center, Little Rock. Sponsored by the Office of Continuing Medical Education at St. Vincent Infirmary Medical Center, Little Rock. CME Category I credit available. Fees: $25.00.

Advanced Cardiac Life Support

October 29, 30 and November 5, 6, 8:00 a.m., Camden. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $150.00. For more information, contact Cindy Reid at (501) 686-5261.

Primary Care Update

October 30, 8:00 a.m., J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Sponsored by Baptist Medical Center Medical Affairs, Little Rock. CME Category I credit available. Fees: $90.00, physicians; $40.00, others.

Arkansas Medical Society Fall Meeting

November 22, Excelsior Hotel, Little Rock. Registration information and meeting times will be forthcoming. For more information, call Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 11:30 a.m., conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided. Category 1 credits available.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times/CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours

Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, rm. 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates from St. Michael Hospital to Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates from St. Michael Hospital to Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st-4th Fridays, 12:00 noon, alternates from Wadley Regional Medical Center to St. Michael Hospital

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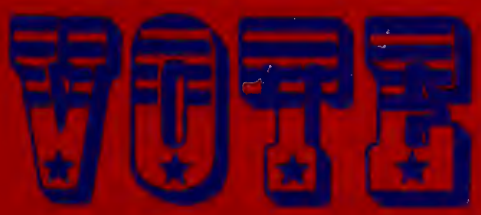

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U.S. Health Care Primary Care Perspective

Larkin M. Wilson, M.D.*

Increasing expenditure for health care in this country is undisputed. All related news items redundantly report the increase in per capita spending in health care and it's increase in the percentage of GNP. Several contributing factors have been identified, but undoubtedly the implementation of Medicare has been the most significant causative factor.

In 1965, Medicare was established to pay medical care for the elderly and Medicaid was in place for the poor. In that year, 86% of the population over age 65 had adequate private insurance. The AMA and others warned Congress of the hyperinflation in medical costs if the Medicare law was enacted. Subsequently, the cost per patient day has escalated. Hospital personnel per occupied bed has multiplied nearly seven fold and cost per patient day adjusted for inflation has increased an astounding 26 times. Cost per patient day rose 6% a year before 1965 and 9% annually since. Regulations have greatly increased administrative expense. With these inflationary pressures has come cost shifting from governmental to non-Medicare and non-Medicaid patient revenue resulting in unbalanced cost sharing.

In the present milieu of economic factors, primary care physicians have major concerns in three areas:

1. **Interference by Government Regulations Resulting in Rationing**

Since October 1, 1987 (OBRA), Medicare has stopped paying for what it considers "not reasonable and necessary" as determined retrospectively by secret computerized government parameters. A few examples of restrictions on payment for services include one hospital visit per day, telephone consultation charges, second opinions by a physician in the same specialty, nursing home and skilled care visits, and restrictions on concurrent care where more than one physician is needed.

The Professional Review Organization (PRO) serve as auditing agencies, and generate multiple reports requiring more and more paper work. Finally, after several years, the PRO at Fort Smith admitted in a recent presentation that their function is not cost effective in regard to preventing unnecessary hospitalization. Expenditures for PRO continue.

Increasing Federal interferences are detrimental to the doctor-patient relationship, and can only result in further reduction in quality care. More and more regulation occurs in spite of the original objectives of the Medicare law to provide improved quality health care. The Act contains within its opening paragraphs the limitation that it is in no way to interfere with the private practice of medicine and "nothing in this Title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which the medical services are provided." Surely it was not the intent of Congress or the desire of the American people that payment for services rendered to critically ill patients be restricted by multiple regulatory policies.

2. **Price Control**

Since June 30, 1983, medical services to Medicare

* Dr. Wilson is an internist in El Dorado, Arkansas.

beneficiaries have been under strict price controls. These fee schedules have been manipulated over the years and allowed charges have been significantly reduced. In the 1960's, my office call was determined by the postage stamp. A $5.00 office call was charged when first class postage was five cents. First class postage has risen to 29 cents and in the near future will be 30 cents. The traditional office call is now limited to a charge of $20.00 by Medicare. Additionally, Medicare only pays the patient or participating doctor about 55% of the charge. Since the increasing price controls for physician charges effect almost half of the sick population, doctors cannot accept the blame for the highly publicized increase in health care costs. Under these strictures, we are now evolving a two tier medical delivery system. One level is the government allowed services based on regulations, rationing, and remunerations by price control. At the other level are patients not subsidized by government who receive indicated services at fair market prices.

3. **Cost to Physician's Practice**

The regulations have required increases in billing cost and additional cost of submitting claims for Medicare-Medicaid patients. Extra time is spent in corresponding with the computerized notices in which we must justify the level of services as well as answering the PRO denials of "medical necessity." Office staffs have been increased with accelerating overhead expenditures in spite of fee restrictions.

"The proposals to enlarge Medicare to encompass a 'universal' system are unthinkable."

Many physicians are beginning to limit Medicare patient load as they did the Medicaid patients in the past. In Massachusetts, the state legislature enacted a law requiring physicians to accept Medicare payment as full fee for service. Over 20% of the primary care physicians could not afford to continue and have left the state. A resulting effect is the increase in hospital emergency room use for inefficient and expensive outpatient care.

Most primary care physicians, if given the option, would conclude that the answer to our increasing medical economic problems is to have the Federal government withdraw from the delivery system as soon as possible. Having seen the deleterious economic results of government intervention in the past 25 years, it would be folly to conclude that increasing it's function would improve our problems and control expenditures. Who can honestly believe that as a result of more government participation there will be a reduction in paper work, overhead, and cost? More and more layers of expensive bureaucracy will be added, as it has in the past when the federal government has expanded it's reach.

The proposals to enlarge Medicare to encompass a "universal" system are unthinkable. Also, cost shifting to employers will be difficult. Some companies are calling for this now in order to reduce fringe benefit expenses. However, more government interference will only require increased rationing and budgetary limitations on the delivery system. The United States is no better at socialism than is England, New Zealand, Canada or other totally socialized countries. Under the socialized plan in England, 15% of the population opts for private care. In New Zealand, one third of the population is under private care by choice. In Canada, private care is forbidden and patients have been streaming across their southern border to obtain care in the United States. Physicians continue to leave these countries to escape the restrictive budgetary control and the enormous tax burden required to support such systems.

In his recent study, economist Milton Friedman concluded that the solution to the crisis would require reform in two major steps:

1. **End both Medicare and Medicaid** and replace them with the requirement that every family unit have major medical insurance with a high deductible based on previous income. Insurance would be paid for by the individual family unit which would receive a reduction in taxes reflecting the reduction in cost of care to the government. Exceptions would be the lower income family and those "unqualified" for medical coverage. Government could help them finance a policy, though not administer it. Private insurers would compete and each individual would be free to supplement insurance in a manner as we did before 1965. He postulates that even if the government were to pay directly for major medical for everyone, rather than reducing taxes, the expenditure for total health cost would decline because of the elimination of the present bureaucratic structure.

2. **End the tax exemption of employer-provided medical care**; it would be regarded as a fully taxable fringe benefit and deductible for the employer. The employee is far more likely to do a better job of monitoring health care providers in his own inter-

est. If tax exemptions were removed, employees could bargain for higher take home pay in lieu of health care.

A system including these principles, and perhaps tax credits for premiums, would solve the problem of the medically uninsured, relieve the possibility of being impoverished by medical catastrophe, eliminate most of the bureaucratic structure, free medical practitioners from an incredible burden of paper work and regulation, lead many employers and employees to convert employer provided medical care into higher cash wage, save taxpayer money since total governmental cost would plummet, and provide incentive for patients to monitor the providers of medical care as well as establish the kind of personal relationship with them that once was customary. The demonstrated efficiency of private enterprise would have a chance to operate to improve the quality and lower the cost of medical care.

Admittedly, to enact this plan would be a difficult task for congress. It would be an admissions of failure at the Federal government level. Such unsuccessful government ventures have generally been expanded rather than terminated. Those who believe that the apparent lack of success is simply a result of not carrying the venture far enough will want to continue to draw on the tax paying public for expansion of the venture. Hopefully, innovative leadership will come forward in Washington to reverse the downhill spiral in the socioeconomics of the medical delivery system. ■

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(A Memorial Tribute to Richard Webber, Ph.D.)

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Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

A pilot. A historian. A board-certified psychiatrist. Southern to a fault. Owen Brodie knows...

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Displeasure with the State Medical Board

I am very disturbed about what is going on in this state in which I recently underwent a lot of shame and embarrassment for practicing what I feel is good medicine. The State Medical Board reviewed some charts in which they felt was "overprescribing" of narcotic medications, Class II and III.

It was interesting in that it was not a unanimous vote, that there was any violation of the Medical Practice Act, yet I still suffered extreme punishment and loss of income because of this.

The cases involved included many different types of cases, 18 different patients. Some of them were postoperative patients, one of them was a cancer patient and some of the patients only received Class IV medications including Darvocet and Xanax. It was presented by the legal representative of the Medical Board that I just overprescribed massive number of medications. He had listed the medications each patient had received. When I reviewed these further, I found that his presentation was far from representative of what actually was going on. In some cases, the patients had received only two prescriptions of Class II drugs over a period of around a year and those were for acute pain. On reviewing the charts, there were probably four that received the medications chronically of Class II or III narcotics.

For this, I was brought to shame by the Medical Board who voted eight to four that I had violated the Medical Malpractice Act. Does that mean those four doctors that voted that I had not violated the Medical Malpractice Act are themselves practicing in the same manner as I am, which was considered malpractice by overprescribing? I think not. What has happened is a physician's judgement has been taken out of his hands and placed in the hands of a Board who has neither the education nor the desire to get the continuing medical education in pain management to be able to judge anyone. As a result of this smear, I was taken off the emergency room staff of three hospitals in the state resulting in my loss of income completely. My office practice is small, and more a service to the community; I made my income working in the emergency rooms. I doubt that I want to "thank the Board," as one of the members had stated during the proceedings, for doing this to me.

It was suggested by my lawyers that I should get out of this state and go back to the east where I would be able to practice medicine in a manner more consistent with my surroundings, but one of my patients asked me if Arkansas did not deserve physicians who were as well educated as those doctors out east. I think they do. I think Arkansas needs to consider continuing medical education for its physicians as a requirement in licensure. I also think they need to investigate into situations, such as mine, where it is a matter of judgement as to whether overprescribing was occurring. I feel a little bit isolated since I am from southern Illinois and "an outsider" when it comes to practicing medicine in Arkansas. I was actually educated further east than that, over in Cincinnati, but I hope and pray that the doctors of this state could become a little bit more tolerant and understanding of people who practice medicine differently, although it is not considered malpractice, as stated by my expert witness from M.D. Anderson Institute in Texas. The matter is under appeal and I hope to get it removed from my record, but the damage has been done. Even if it is removed, it will always have to be stated on applications that it happened, and anyone who dares to fight the system and appeal bad judgement is labeled for life.

It must be noted that there is much more to this situation than can be stated in a letter of this length, but I think there needs to be some change if there is going to be any progress in this state, or advancement in medical care, and the only thing that will result, if it is not changed, is stagnation in the practice of medicine in this state since no outside or new information will be channeled in very quickly.

Sincerely,

Michael G. Langley, M.D.
Walnut Ridge, Arkansas

Coalition For A Healthier ARkansas

P.O. Box 251505, Little Rock, AR 72225-1505 (501) 663-SMOK

Dear C.H.A.R. Campaign Chairman:

I have read about the upcoming campaign for an initiated act to further tax tobacco sales in Arkansas, and I want to help all I can before the Nov. 3 vote.

Please contact me as a volunteer to:

__ Display yard signs at my home or office.

__ Help set up and direct a county campaign headquarters.

__ Participate in a campaign speakers' bureau for civic clubs and other community groups in my vicinity.

Enclosed please find my check (or money order) in the amount of:

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$250 _____ $100 _____ $_____

Name _____

Mailing Address _____

City_____ State _____ Zip _____

Phone _____ _____

(day) (evening)

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Coalition for a Healthier Arkansas

Steering Committee

William N. Jones, M.D., Chairman

November 3rd - It's Your Choice!

The general election is just around the corner. The Coalition for a Healthier Arkansas (CHAR) has released three ways you, as a respected physician, can help assure victory for the cigarette tax in November:

✔ **Talk to your patients about the proposed initiative**

Let them know that even though you might not agree on local state or national races, there is one proposal that all should agree on if they care about the health of Arkansas.

Let them know that a tax increase has proven to reduce smoking among teens and adults.

Point out that the television ads they have been seeing are being purchased by the out-of-state big tobacco companies who are losing 450,000 customers a year. They target youth and minorities to recoup that loss of customers.

Let them know that money will go to the schools to educate kids about addictive behavior, warning them of the dangers of smoking, drugs and alcohol.

Let them know that research dollars from the tax will stay right here in Arkansas.

If the patient is elderly, let them know that the money will be spent to increase services for the elderly - meals on wheels and transportation for health care.

✔ **Talk to your friends about the proposal**

Your opinion carries a lot of weight and will be effective when you stress the health aspects of the proposal.

Use the same approach you do with patients but also stress the fairness of the proposal by pointing out that no one is forced to pay the tax.

Also let them know that no new government agency will be established because of the tax. All the money will be administered by existing agencies.

✔ **Make sure your family, staff and associates are educated** on the proposal. Make sure they all vote.

✔ **Make sure that you can answer "yes"** when asked if you have done all you can financially or in a volunteer capacity for this proposal which is so critical for your profession.

Update on the Progress

In a petition filed August 20, the Arkansas Executive Committee challenged Secretary of State Bill McCuen's certification of the Cigarette and Tobacco Products Tax Act initiative.

The Executive Committee, the front for the tobacco industry in Arkansas, asked the Supreme Court to do three things:

1. Certify that there were not enough valid signatures to place the Act on the ballot.
2. Find that the ballot title was faulty.
3. Appoint a master to investigate its charges.

The Executive Committee did not bring suit against CHAR, sponsors of the Tax Act and leaders of the petition drive.

CHAR has responded to the filing of the lawsuit by saying that it was expected and again expressed confidence in the legitimacy of its petitions.

CHAR reported that tobacco interest are known for filing suits against similar measures in other states. The Massachusetts petition drive has already had to withstand two court challenges.

CHAR, which will join in the case to protect its interests, expressed confidence in the outcome of the suit, reminding supporters that the Executive Committee had made similar charges to Secretary of State Bill McCuen before he certified the petitions. The purpose of the suit, CHAR believes, is simply to try and financially drain the Coalition with legal expenses and to direct attention away from the November election.

The Executive Committee, in its filing before the Court, offered no evidence to support its charges.

Dr. William N. Jones, CHAR Steering Committee Chairman, issued a call for all supporters to make a donation to CHAR for legal expenses so that money planned for the campaign will not be diverted. "If we can get the message to the people, we know we will win, and tobacco knows we will win," Dr. Jones said.

Campaign Contributions

From July 24 to August 26, the tobacco companies poured another $150,000 into the state in their attempt to defeat the proposed tax increase on cigarettes and other tobacco products.

As of August 26, tobacco had contributed $356,896 in its campaign against the initiative offered by CHAR.

P. Lorillard Tobacco Company alone contributed almost $100,000, making a $96,298.92 donation on August 25.

All of the funds were made to the Arkansas Executive Committee, the front for the tobacco interests in the state.

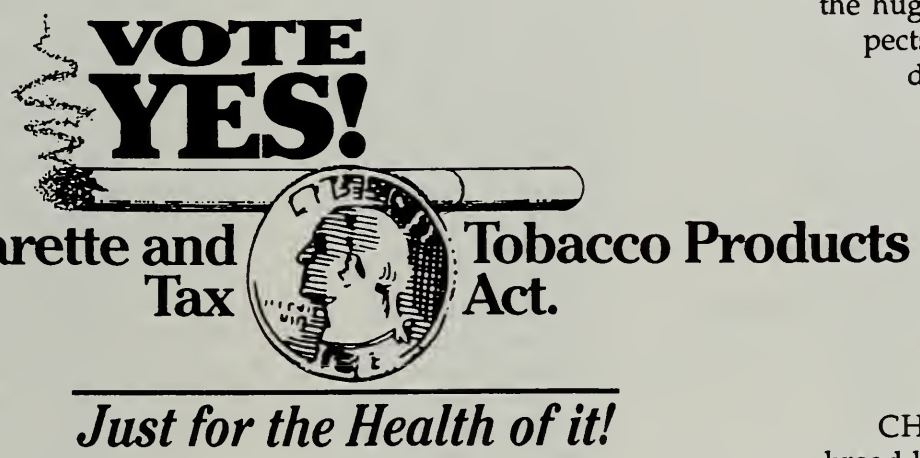
In the Executive Committee's filing of its contributions and expenses, they reported no gifts under $250 and no contributions from any person in Arkansas - only out of state tobacco companies or the Tobacco Institute.

The largest expense reported on the report was a $82,787 payment to the Friday Eldredge and Clark law firm. The Friday firm has filed a petition with the Supreme Court to challenge the ballot certification of the tax.

CHAR, in its last filing with the Secretary of State on July 31, reported that it had raised a total of $108,170 in the state since it began its campaign in March. CHAR has reported numerous contributions under $250 and all of its donations have been from Arkansans and their organizations.

Dr. Jones has urged supporters to send in contributions to fight the massive tobacco dollars as the time for the election media campaign begins.

"Five and $10 contributions from our tremendous grass-root support can do effective battle against big tobacco," Dr. Jones said.



Getting the Message Out

CHAR with its 60 member organizations, is about as "All-Arkansas" as you can get, but beginning this month CHAR has teamed up with the state's best know institution, the Razorbacks, to get its message across the state.

The first media purchase by CHAR is for radio advertising during the broadcasts of the Arkansas Razorback football games. John Roberts, CHAR account executive for Bob Sells PR Associates, said that the loyal following of the Razorbacks crossed all demographic lines and was an excellent way to economically encounter the huge dollars he expects the tobacco industry to spend on advertising.

Mr. Roberts said that he expected grass-root support for CHAR to be as broad-based as support for the Razorbacks when people are informed of the benefits that will accompany the increase in taxes on tobacco products.

The last filing the Arkansas Executive Committee made with the Secretary of State on its contributions and expenses, showed that they had made payments of more than $57,000 during August to three public relations firms, two direct marketing firms and a telemarketer. All the firms but one were from out of state.

Mr. Roberts said that he had received information that the tobacco interests had presented to a focus group a sample of some six television commercials they had produced for the Arkansas market.

CHAR expects to be outspent in media advertising by a ratio of 10:1, Mr. Roberts said, adding, "We've got to make smart buys, and we believe the Razorbacks are one." ■

COALITION FOR A HEALTHIER ARKANSAS

P.O. Box 251505, Little Rock, AR 72225-1505 **(501) 663-SMOK**

The following physicians have contributed to the Coalition for a Healthier Arkansas, an effort endorsed by the Arkansas Medical Society. If you would like to add your name to the list of supporters, complete the pledge card located at the top of page 229 and return it to CHAR.

Lawrence J. Abramson, M.D.
Jim Acklin, M.D.
Arkansas Allergy Clinic of Little Rock
H. Daniel Atwood, M.D.
Scott Bailey, M.D.
Jeffrey Barber, M.D.
Mark E. Barnard, M.D.
Beverly Beadle, M.D.
Glen W. Beasley, M.D.
James Beckman, M.D.
Mike Berumen, M.D.
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Lawrence Braden, M.D.
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Ann Maners, M. D.
Mahlon O. Maris, M.D.
Steve Marks, M.D.
F. Allan Martin, M.D.
Kenneth Martin, M.D.
Peter Marvin, M.D.
Robert Matthews, M.D.
Jane Mauch, M.D.
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- American Cancer Society, Arkansas Division
- American Heart Association, Arkansas Affiliate
- American Lung Association of Arkansas
- American Medical Association
- Arkansas Academy of Family Physicians
- Arkansans for a Drug Free Youth
- Arkansas Advocates for Children and Families
- Arkansas Association of Area Agencies on Aging
- Arkansas Association of Home Health Agencies
- Arkansas Blue Cross and Blue Shield
- Arkansas Cancer Research Center
- Arkansas Dermatological Society
- Arkansas Gerontological Society
- Arkansas Health Care Association
- Arkansas Hospital Association
- Arkansas Impact
- Arkansas Medical Society
- Arkansas Nurses Association
- Arkansas Opthalmological Association
- Arkansas Optometric Association
- Arkansas Perinatal Association
- Arkansas Pharmacists Association
- Arkansas Public Health Association, Inc.
- Arkansas Society for Public Health Education
- Arkansas Speech-Language-Hearing Association
- Arkansas State Board of Health
- Arkansas State Dental Association
- Arkansas Thoracic Society
- Arthritis Foundation, Arkansas Chapter
- Campaign For Kids Coalition
- College of Medicine Faculty, University of Arkansas for Medical Sciences
- CARTI
- Governor's Advisory Council on Aging
- Lost Chord Club of Central Arkansas
- March of Dimes Birth Defects Foundation, Arkansas Chapter
- Medical Equipment Suppliers Association of Arkansas
- Mental Health Council of Arkansas
- National Association of Social Workers, Arkansas Chapter
- The Presbytery of Arkansas
- Presbyterian Urban Council
- Retired Senior Volunteer Program
- United Methodist Church, Little Rock Conference
- United Methodist Church, North Arkansas Conference
- Youth Home, Inc.

OR ONE OF THESE?

BIG, POWERFUL TOBACCO COMPANIES AND THEIR FRIENDS

This message brought to you
by your friends at the
Coalition for a Healthier Arkansas,
Russ Rawn, Treasurer

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Cigarette and Tobacco Products Tax Act.

Just for the Health of it!

Seventh Annual

ARKANSAS

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Update of the Worldwide FDA Study of the 3M Diffractive Multifocal Intraocular Lens

F. Hampton Roy, M.D.*

The multifocal diffractive intraocular lens (IOL) represents a significant technological advance. Results of 671 patients with a year follow-up from a worldwide study are presented. Through this FDA study, it appears that many patients can enjoy uncompromising distance vision as well as unaided near vision. With careful surgical control of astigmatism and competent calculation of IOL power, it may be possible to reduce the post-cataract patients' dependency on glasses.

A cataract is a cloudiness of the natural lens of the eye. When removed, the lens is usually replaced with an artificial lens inside the eye. Currently, over two million intraocular lens (IOL) implantations are performed in Europe and America each year.[1]

Many changes have evolved since the first IOL was implanted in 1949. Currently, most IOL implant patients have good distance vision but still require reading glasses or, perhaps bifocal glasses, because the conventional IOL cannot accommodate (change focus). Some of the newest IOL technology involves a diffractive multifocal IOL.[2] This lens possesses two powers. It utilizes simultaneous vision when two images are formed at different axial locations. Distant objects are correctly imaged by one power and near objects are imaged by the other (Fig. 1-4). In each case, one image is in focus at the retina, and the other is highly defocused with little structure. The object distance determines which power is used. This diffractive multifocal IOL has the potential to improve significantly the quality of life of postoperative IOL patients, since it provides lens powers for both near and distance vision.

Over 30,000 multifocal diffractive intraocular lens have been implanted since 1987 worldwide.

Table 1. "Functional" Visual Acuity Without Glasses at 1 Year

	Overall n = 671	Best Case* n = 496
At distance 20/40 or better	57.0%	63.1%
At near 20/40 or better	78.2%	81.5%
At distance and near 20/40 or better	46.7%	50.2%

* Best case excludes patients with pre-operative pathologies and macular degeneration at any time.

* Dr. Roy is an ophthalmologist with the Arkansas Cataract Center in Little Rock.

Patients and Techniques

A Food & Drug Administration (FDA) clinical study of 3M Diffractive Intraocular Lenses began in November 1987 and includes 1000 patients from the United States and Europe. Each patient met the strict criteria set up by the FDA study.[3] Various surgeons performed either extracapsular or phacomulsification cataract removal. All of the intraocular lens implants were the posterior chamber type. Drs. Robert Berry and Hampton Roy of Little Rock, completed 40 multifocal intraocular lens implantations for this FDA study.

Table 2. Near Vision with Best Distance Glasses and No Bifocals

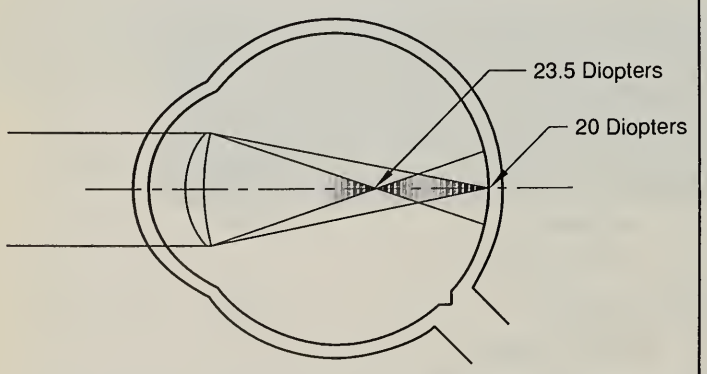
	Overall n = 671	Best Case* n = 496
At near 20/40 or better	86.0%	89.0%

* Best case excludes patients with pre-operative pathologies and macular degeneration at any time.

Results

As of March 1991, 671 patients had reached one year postoperative follow-up. For the overall group, 46.7% achieved both functional distance and near visual acuity without glasses. When patients with pathology were eliminated, these numbers improved to 50.2% (Table 1). Excellent near vision was obtained in 86% of the cases without a bifocal when the distance vision was corrected with glasses. (Table 2)

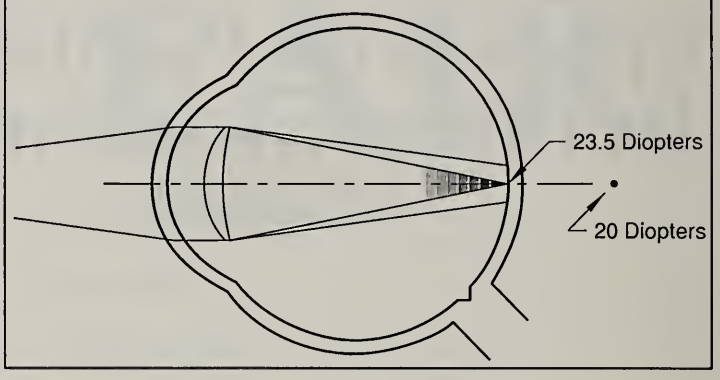
Figure 1. Distance Vision



The visual acuity with this diffractive multifocal lens was unaffected by changes in pupil size or lens decentration because all "zones" of the lens contributed equally to both distant and near focal points.

Contrast sensitivity was a performance issue for multifocal lenses because splitting of light into two images could result in a reduction of contrast at the retina. Ninety-four percent of the patients in the study, however, observed no difference in contrast sensitivity.

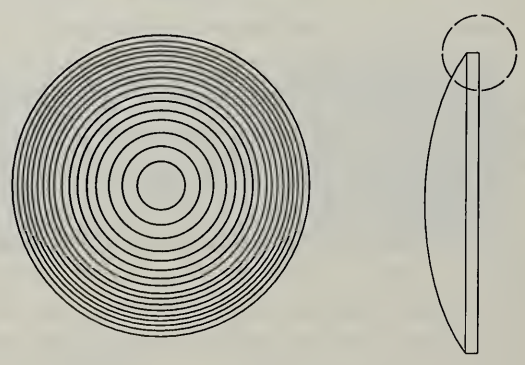
Figure 2. Near Vision



Comment

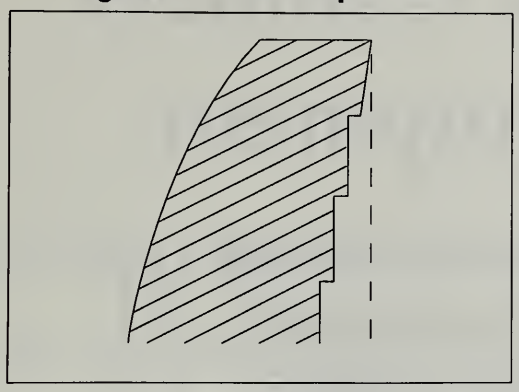
The general indications for implantation of a multifocal lens are similar to those for a conventional monofocal lens. Patients were identified who had preoperative pathologies and macular degeneration but not eliminated. Implantation considerations include the presence of ocular pathology and potential visual acuity, preoperative astigmatism, status of the fellow eye, functional or occupational requirements of the patients, and realistic expectations for post-surgical spectacle use.[4]

Figure 3. Multifocal IOL



As surgeons in this study have gained experience with the lens, they have each developed a set of patient selection criteria and an approach to counseling about realistic expectations with which they have had the greatest success.

Figure 4. Zone Step Detail



A recent article demonstrates that 63% of multifocal cases vs. 4% of monofocal cases need no spectacle correction for functional vision.[5] Patients must realize with multifocal intraocular lens that there is a reduced dependency on glasses but, as this study shows, 50% of the patients will require glasses for their very best visual acuity.

References

1. Simpson MJ. The diffractive multifocal intraocular lens. Eur J Implant Ref Surg, 1989; 1:220-228.

2. Hansen T, et al. New multifocal intraocular lens design. J Cataract Refract Surg, 1990; 16:38-41.

3. Lehmann RP. Experience with 3M diffractive multifocal IOL: follow-up on a small series. Implants in Ophthalmol, 1989; 3:74-76.

4. Percival P. Indications for the multizone bifocal implants. J Cataract Refract Surg, 1990; 16:193-197.

5. Gimbel HV, et al. Visual and refractive results of multifocal intraocular lenses. Ophthal, 1991; 98:881-888.

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* Data was collected and collated by 3M Vision Care, 3M Center, St. Paul, Minnesota 55144-1000. 3M has approved publication of this data. The 3M Diffractive Multifocal IOL has now been sold to the Alcon/Cilco Company, Fort Worth, Texas.

This data was submitted to the FDA ophthalmic panel and approved in January 1992. The 3M Diffractive Multifocal IOL will become available for general usage in the United States in 1992.

The FDA has set up the criteria for this study and all other multifocal intraocular lens will adhere to these same standards. ■

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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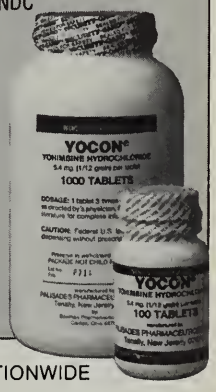

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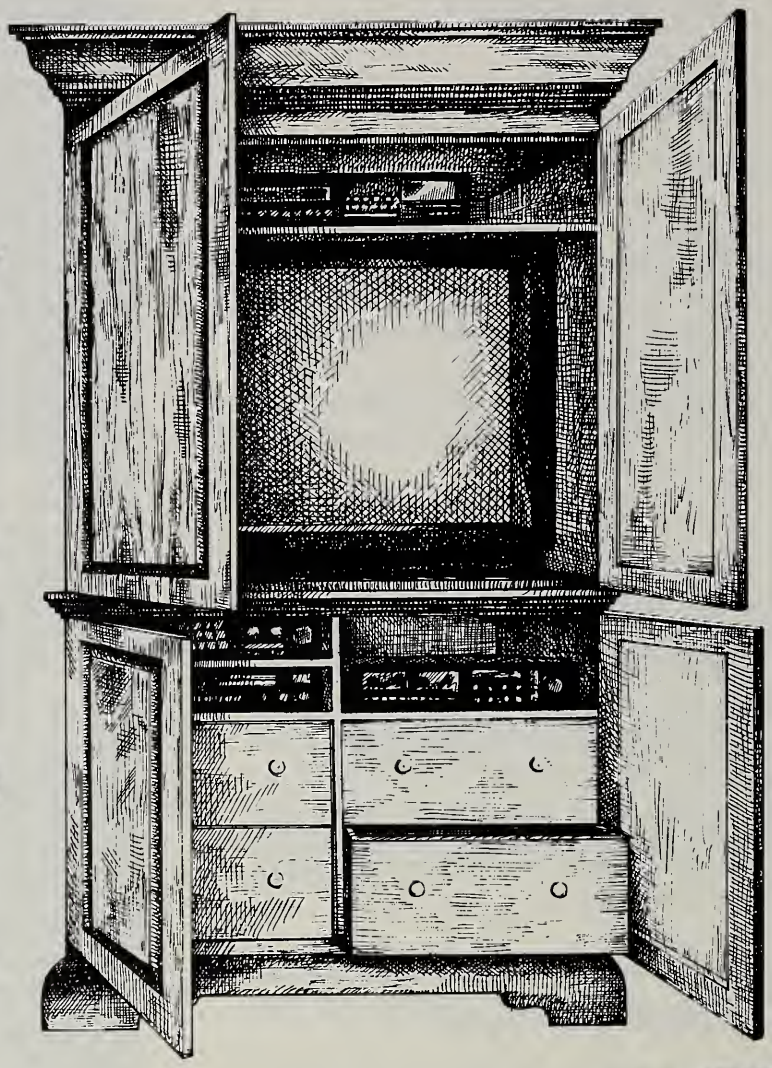

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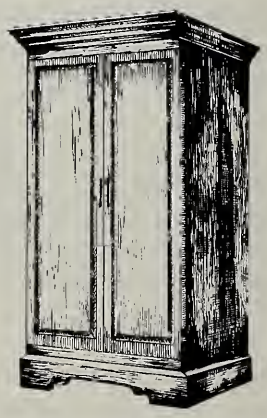

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Torsion of the Gallbladder A Review of Four Cases

John D. Olson, M.D.*
John H. Wikman, M.D.*

Torsion of the gallbladder is a rare entity, and probably no more than 300 cases have been reported in the world literature. Most of these reports consist of a single, or at the most, a few cases, submitted for publication.[1-4] Four cases were reported by Ingwang, et al 1991.[5] The entity is only briefly mentioned in our standard textbooks of surgery (Schwartz & Sabiston). These textbooks describe an anatomical anomaly labeled as a "floating gallbladder" which can lead to torsion. In order for torsion to occur, the gallbladder must have a very mobile mesentery allowing the organ to "hang" or "float," permitting torsion to occur with subsequent gangrene developing due to vascular embarrassment. If surgical intervention is not done, death can very well result. The first case was reported by Wendel in 1898.[6]

Clinical Findings

Except for a few cases reported in the literature in children,[7-9] most of the cases reported occur in the elderly, and is most likely to occur in a thin, kyphotic female who presents with acute abdominal pain occurring usually within the previous 24 hours. The correct diagnosis is rarely made. The usual preoperative diagnosis is appendicitis, as the ptotic organ frequently lies in the lower right abdomen. A mass can occasionally be found. Muscle guarding and tenderness are present, and a surgical abdomen is apparent. The true diagnosis can also be mistaken for an acute cholecystitis. Gallstones are present in approximately 50% of the cases, but are not essential for the development of the pathological picture. Two of our four cases had biliary calculi.

The average age of the four cases presented is 85 years. Three were thin females, and one a thin male. Three cases were in the Fort Smith area, and one was from the Veterans' Hospital in Fayetteville. The laboratory findings are not diagnostic. Leukocytosis may be present.

Case Reports

Case #1

This was an 88 year-old female taken ill the preceding day (9/15/72) with abdominal cramping and vomiting, with the pain becoming worse recently and presenting in the right lower abdomen. Upon examination she was found to be an elderly, thin, Caucasian female in acute distress. Her abdomen was found to be acutely tender in the right lower quadrant with muscle guarding and rebound tenderness. A preoperative diagnosis of probable acute appendicitis, or more unlikely, gallbladder disease, was made, and she was taken to surgery within a short period of time. (J.D.O.) While she was under anesthesia, a pear-shaped mass could be palpated lying transversely in the right abdomen just lateral to the umbilicus.

Upon opening the abdomen, the gallbladder was

* Dr. Olson and Dr. Wikman are from the surgical department of the Holt-Krock Clinic in Fort Smith.

found to be gangrenous and rotated upon itself in a clockwise fashion, producing a complete torsion. The mesentery of the gallbladder was found to be very "lax," and this had allowed the torsion to occur. The common bile duct was found to be enlarged to about 2cm. After "untwisting" the gallbladder, a cholecystectomy was performed. A common duct exploration was carried out, and several small calculi were found and extracted. T-tube drainage of the common duct was done. Upon opening the specimen following the surgery, several small calculi were found.

This patient made an uneventful recovery.

Case #2

This 87 year-old female was admitted to the hospital (3/1/74) with nausea, vomiting and abdominal pain which had started on the evening previous to her admission. The pain had become increasingly severe and localized in her right abdomen, where she thought she felt a "lump."

Figure 1. Gangrenous Gallbladder

On examination, she was found to have a palpable, very tender mass in the right lower quadrant, with muscle guarding and rebound tenderness. A diagnosis of appendicitis with probable perforation was made, and she was taken to surgery immediately (J.D.O.). Torsion of the gallbladder was found, occurring in a clockwise fashion, and the entire gallbladder was found to be gangrenous. A very redundant mesentery was found. A cholecystectomy was performed, and the patient made an uneventful recovery. No calculi were found in the gallbladder (figure 1.)

Case #3

This patient was an 87 year-old female admitted to the hospital (6/21/76) with severe right-sided abdominal pain which had begun two to three days previously, and was associated with nausea and vomiting, with the pain becoming progressively worse prior to admission to the hospital. Previous to this, she had lost a considerable amount of weight and had sustained multiple fractures secondary to severe osteoporosis.

On examination, she was found to be a thin, elderly female appearing to be acutely and chronically ill. Severe Kyphosis was present. Marked tenderness with muscle guarding was found in the right abdomen with a suggestion of a mass being present. A presumptive diagnosis of acute appendicitis was made, and she was taken to surgery. (H.H.M.)

At surgery, the gallbladder was found to have a long, redundant mesentery, and torsion of the gallbladder with a 180 degree "twist" was found. The common bile duct was dilated to 2 centimeters. The torsion was reduced, and cholecystectomy was performed, along with exploration of the common bile duct. The gangrenous gallbladder contained several calculi, but no stones were found in the common duct. Initially the patient did well, but developed cardiopulmonary problems and expired three days following surgery. It was felt that had she sought help earlier, a different outcome may have ensued.

Case #4

This 79 year-old thin male, weighing 124 pounds, height 5'10", was admitted to the VA Hospital in Fayetteville primarily for treatment of chronic obstructive pulmonary disease. While in the hospital, he developed severe right-sided abdominal pain. On examination, he was found to be markedly tender over the gallbladder area, and diagnosis of acute cholecystitis was made.

Surgery was carried out (S.H.) (2/15/73) and at the time of surgery, the gallbladder was found to be on a long mesentery. Torsion had occurred, producing subsequent edema and vascular embarrassment. A cholecystectomy was performed, and the patient made a good recovery. No calculi were found in the gallbladder following surgery.

Summary and Conclusion

Four cases of torsion of the gallbladder have been gathered from this area. Three were admitted to our local hospitals and the fourth case occurred in the Veteran's Hospital in Fayetteville.

The average age of these four cases was 85, and all patients were very thin. Three patients were female and one was male. One patient died following surgery. This patient had sought help rather late, and died of cardiopulmonary complications.

This entity is rare, and only scattered cases are found in the literature. Biliary calculi are found in approximately 50% of the cases. The exact etiology of the torsion is unknown. A redundant mesentery is always present, and kyphosis is frequent. Our patients were all thin. Botha has postulated that vigorous peristalsis in the neighboring viscera or sudden body movement may be responsible. The diagnosis is rarely made

preoperatively, but if surgery is not done, death will probably ensue. Later reports have indicated that sonography and abdominal CT scanning might prove helpful in establishing a diagnosis.[10,11]

Acknowledgement

I wish to extend my thanks to Dr. Harold H. Mings for giving permission to present Case #3 and Dr. Sam Huckey of the Veteran's Hospital in Fayetteville for Case #4.

References

1. Mucha P, Schlinkert. Torsion of the gallbladder. Mayo Clinic Proceedings, 1984; 59:490-92.
2. Alden P, et al. Volvulus of the gallbladder - report of two cases and review of the literature. Minnesota Medicine, November 1989; 72:653-55.
3. Kersten HH. Torsion of the gallbladder - three case report. Journal of the Iowa Medical Society, June 1972; 287.
4. Echave V, Hampson LG. Volvulus of the gallbladder - case report and review of the literature. Canadian Journal of Surgery, September 1975; (18) 439-41.
5. Ingwang, et al. Australian and New Zealand Journal of Surgery, September 1991, 61 (A) 717-19.
6. Wendel AV. A case of floating gallbladder and kidney complicated by cholelithiasis with perforation of the gallbladder. Annals of Surgery, 1898; 27:199-202.
7. Pinto DJ. East African Medical Journal, Vol. 48, #11, November 1971.
8. Chilton CD. Journal of the Royal Society of Medicine, 1980. February, 73 (2) 141-43.
9. Giurses. Turkish Journal of Pediatrics, 1979; January 21 (1) 7-10.
10. Merine, et al. CT scan diagnosis of gallbladder torsion. Journal of Computer Assisted Tomography, 1987. July-August, 11 (4) 712-13.
11. Miyata, et al. Japanese Journal of Surgery, 1986; July 16 (4) 298-301. ■

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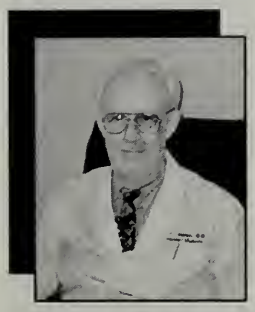


Dr. Owen H. Clopton Jr.

Over the past 40 years, the practice of medicine in Arkansas has undergone tremendous changes, not only in the science of medicine, but in the very practice of medicine. The increased amount of paperwork required from the numerous agencies, companies, and firms, has become a major item that if not faced daily, will not only result in a literal glut of paper, but threats of nonpayment and civil penalties. The day of the one doctor, one nurse, one receptionist, is gone. The requirements of modern medicine requires a trained and competent staff to assist the physician to enable him to continue to practice medicine and not merely be a form "signer."

Medicine has also not so subtly been transformed from a profession to a competitive business. There is more advertising, more educational services, and more demands made on physicians and staff. There is a need for more efficient time management, more courteous employees, more flexibility, and an urgent need for the patient to become a person who deserves to be treated promptly, with courtesy, and as if they are the only patient in the office at that time.

All the demands being placed on the medical profession today demands the best from everyone. This begins with the telephone receptionist, the office receptionist, the nurse, the M.D., and everyone involved in the delivery in care. The Society of Medical Assistants plays a role in all this that is vital and can not be measured in time for dollars and cents. The members are able, through the Society, to learn the skills necessary for them to be an effective employee. The Society provides a common forum to share problems, explore answers, and experience a camaraderie with others with the same problems. It helps build self-esteem through knowledge, and experience the satisfaction of doing a job well.

The Medical Assistants Society is potentially an important tool in every doctor's office in Arkansas. The physicians should be willing to subsidize their employees by giving, not only money, but allowing time for activities. The physician can also have an impact by sharing not only his medical knowledge, but be willing to participate in local Society meetings. The Society is a dedicated group whose goal is better medical care in Arkansas.

Owen H. Clopton Jr., M.D.
Internal Medicine Associates, P.A.
Jonesboro

Shelia Hamrick

One of the most important decisions a physician makes is hiring medical assistants. A physicians who is aware of the many changes that occur daily in a medical office, should choose a medical assistant willing and capable of staying in touch and making the transitions necessary to have a successful and profitable practice. The medical assistant should be knowledgeable in general, clinical and administrative areas. The American Association of Medical Assistants, Inc., is a tri-level organization designed to assist the medical profession with continuing education and cultivating relationships with medical

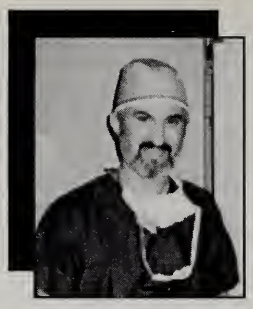
practices throughout the United States of America. One of the most important things it can assist with, is improving the self-confidence and self-esteem of its members.

The medical assistant plays an important role in the medical office. They are the first person the patient comes in contact with before seeing the doctor and the last person they see before leaving. If the medical assistant handles a stressful situation in an inappropriate manner, it reflects on the physician and staff. The need of a physician brings the patient into the clinic and then the medical assistant takes over to file the insurance, make the return appointment, schedule the necessary test, type the pertinent information into the patient's record, answer the telephone, and transfer the calls. It takes a joint effort of every member of the staff to keep things running smoothly and efficiently. The American Association of Medical Assistants, Inc. has been the turning point in my career and has taught me to be more productive than I ever thought possible. My association with the Arkansas Society of Medical Assistants, Inc. and the American Association of Medical Assistants, Inc., has given me the opportunity to pay my employers back for supporting me financially and I am returning their investment by becoming a more efficient employee.

The American Association of Medical Assistants, Inc., the Arkansas Society of Medical Assistants, Inc., and the county chapters in the state are more than willing to come and establish an organization in your county. Physicians, encourage your employees to investigate the Arkansas Society of Medical Assistants, Inc., and your support will be returned by your staff in ways that can make your practice run more efficiently, lessen the stress you have, increase your profits, and last but not least, have a better understanding of what our profession is all about, caring for the sick, having compassion for the needy, and sharing ourselves with those who have no one. I would like to end my plea to the Arkansas Medical Society by sharing with them the medical assistants creed.

I believe in the principles and purpose of the profession of medical assisting. I endeavor to be more effective. I aspire to render greater service. I protect the confidence entrusted to me. I am dedicated to the care and well-being of all patients. I am loyal to my physician-employer. I am true to the ethics of my profession. I am strengthened by compassion, courage, and faith.

Shelia Hamrick, CMA
Arkansas Society of Medical Assistants, President
Internal Medicine Associates, P.A.
Jonesboro


Dr. Steven D. Shorts

Not long ago, several ex-medical school classmates and I met on a fishing trip for the purpose of renewing old friendships and sharing with each other developments in our individual practices over the last 10 or 15 years.

During the course of our wanderings and our philosophizing, the question of how each of us has dealt with the multiple changes in medicine over the last few years arose, particularly regarding office management, filing for insurance claims, complying with Medicare and Medicaid regulations, abiding by new CLIA regulations, and in general just maintaining normal practice while complying with all of the external regulations. Everyone had his own stories about the headaches involved with keeping an office staff up to date on all the requirements that the practice of medicine imposes upon us now days. There was a particular feeling of uncertainty as to the implementation of some regulations since, in many of them, there seems to be not only some leeway as to whether the regulation applies, but also some interpretative judgement to be made as to the degree of compliance.

Well, as you can imagine, the discussion rambled on regarding all of our concern about the "external" controls placed on us, but also turned to more of the "internal" problems involved in maintaining a large office. Since none of us were reared in the computer age, we had all relied on the younger folks in our offices to update us and keep us abreast of new developments in billing, record keeping, collections, and efficient office management. During most of the discussion, I sat quietly in the background trying to figure out how to use one of the fine, new fishing reels my children had given me for Christmas, which in and of itself was a task. Finally, one of my colleagues turned to me and mentioned that I had been awfully quiet during all of this, and he wondered if I shared their feelings and concerns.

Being the only member of the group practicing in Arkansas, which they generally viewed as a predominantly rural area, I thought for a moment and finally blurted out "I leave it up to my Ma." Not unexpectedly, two of the fellows turned and looked at me inquisitively and in startled voices said, "What?" Having gained their full attention and not wanting to let the moment slip away, I proceeded to describe to them how we have managed to not only comfortably comply with all of the new regulations handed to us, but have actually been in a leadership position in our community regarding our office staff and its managerial scheme.

Knowing that the term "Ma" conjured up visions of a rural atmosphere which is fairly characteristic of Arkansas and which also was fulfilling their expecta-

tions of what they thought my practice must be like, I outlined what my "Ma" actually does. After having as much fun as I could with it, I finally volunteered the fact that "Ma" actually stood for medical assistant. After seeing the expressions on their faces change with that revelation, it was obvious that they became much more interested in what, for the next several minutes, was some verbal gymnastics.

If one could look back over the past nine years at our particular office situation, he would see a crew growth from 12 to approximately 25, and realize the enormous changes that have taken place in both managerial structures of offices as well as governmental control imposed upon the practice of medicine. Not only have the day-to-day workings of the office become more complex, but the simple communications done on an interoffice basis are more frequent, and the record keeping and day-to-day calculations have become increasingly burdensome. Were it not for the fact that the medical assistants organization is directed towards efficient office management as well as education of office personnel to the changing world of office management, those physicians in our group would be severely burdened with what we consider the nuisance part of medicine.

With the communications network set up by the medical assistants, they are able to share on a local, statewide, and national level trending and innovative developments in government, business, and the medical profession. Their ability to pull pertinent information and new technologies from those various sectors greatly improves their ability to streamline the day to day office functions in a medical practice. Seeing our medical assistants share their ideas and information with other offices gives us a great deal of pride since we maintain a significant leadership position in our community. Hardly a month goes by that another office is calling ours to request aid in setting up some new billing system, applying some new software for collections, constructing the new instructional manuals for OSHA, or for something as simple as interpreting a new directive from Blue Cross Blue Shield.

At that point, I stopped and actually for the first time realized that I had never experienced the headaches or genuine concerns that my colleagues had regarding their practices, and that the more I talked, the more I appreciated what my "Ma" actually did.

Most of us in medicine are egotistical enough to feel that we have supreme managerial skills and that there is little beyond our comprehension, but when one sees the myriad of different forms involved in office work nowdays, the ever changing regulations that are handed down on what seemed like a monthly basis from innumerable agencies, and the new developments in soft and hardware, there is no logical way that a person in active medical practice can stay abreast of all the developments and maintain peak efficiency in the running of his office without the help of an expert.

Our medical assistants are our experts. Through their exchange of ideas and their innovations in office management, they are able to fulfill the requirements of a busy practice in a more efficient and precise manner. They take what most of us consider the day to day chores of medicine and miraculously transform them into the pleasures of being in private practice.

Although it may sound quite trite, I know that every morning that I go to my office and every afternoon when I leave, my "Ma" is watching out for me, and that her guiding and nurturing hands are making my practice and my life much better.

Stephen D. Shorts, M.D.
South Arkansas Ear, Nose and Throat Clinic
South Arkansas Surgery Center
Pine Bluff

Gail B. Shelton

As a 12 year member of the Arkansas Society of Medical Assistants, I would like to share with you how this organization has enriched me both personally and professionally.

In 1973, I began working as a floater in a 10-physician practice in Union City, Tennessee. This set in motion a great learning experience for me. Soon I was processing insurance claims. That was in the days when you took pencil and paper and just sat down and did insurance.

My husband was transferred and we moved to rural Greenfield, Tennessee, where I worked for a general practitioner. We saw 50 to 75 patients per day, made house calls and nursing home visits. Other than the nurses, this was a one-girl office. This was medicine from a totally different perspective, and offered me another great opportunity.

Our next move was to Pine Bluff. I was very fortunate to be hired by Drs. Wayne Buckley and Lloyd Langston. I went to work for this ENT practice part-time, again in the insurance department. We had eight full-time and two part-time employees.

A year later, I was asked to join a local Medical Assistant's group. I was a little reluctant to do this, but they were persistent. In retrospect, both from a standpoint of my career in the medical field and my growth as a person, it was certainly one of the most important decisions I have ever made.

I soon learned that just because you belong to Medical Assistants and attend a few meetings, this is not going to make you "the wonder woman of the office." It, however, does give you the vehicle that can take you

where you want to go. The rest is up to you. The timing was perfect and I am glad I joined. We were growing very fast, and in 1981, I became the office manager. Within two years, Dr. Stephen Shorts, who did facial cosmetic surgery, came on staff as our third physician.

In 1990, we opened South Arkansas Surgery Center, and I became the administrator of that facility as well. We now have 27 full-time and two part-time employees.

Fortunately, from the day I became associated with these physicians, they have recognized the need for continuing education. Also, they wanted their office to have the best personnel available. In this way, patients receive the very best quality of care. Our professional image and networking potentials are areas that can make a tremendous difference in how effective we are in our chosen profession.

The Arkansas Society of Medical Assistants gives us the opportunity not only to network locally but across the country. We can be effective through the legislative process and make our voices heard to help our physicians and patients.

I would certainly recommend this organization to any person who works under the direction of a physician. The membership dues are reasonable. You can earn the professional status of CMA which is a Certified Medical Assistant. The CMA credential is awarded to those who successfully complete the certification exam. There are numerous educational programs sponsored throughout the year by local, state and national groups. These programs are designed to help medical assistants stay abreast of current developments and the administration of health care. There are several different publications. *The Bulletin* is published by the Arkansas Society of Medical Assistants three times annually which contains organizational news as well as informative articles pertaining to medical assisting. *The Professional Medical Assistants* is published bimonthly by the AAMA, and offers articles written by experts in the medical profession. Organizational news is published through the official AAMA newsletter, *The Byline*.

As a member of the Arkansas Society of Medical Assistants, you will gain stature in your career in the community. I have put to work in my personal career every aspect of the association of medical assisting. There will be opportunities to participate in meetings and educational programs within the organization. You will meet a group of professionals who share common interests and goals. This organization promotes self confidence and a feeling of personal achievement, and allows you to enjoy the satisfaction of knowing that you are good at your chosen profession. I have been rewarded in more ways than I can tell you through this Society, and it has inspired me to be active in my local chapter, and to be of service on a state and national level.

Sharing is a big part of this organization. As we learn, we share with others in the group in an effort to give back some of what this Society gives to us.

Gayle B. Shelton, CMA
Administrator
South Arkansas Ear, Nose and Throat Clinic
South Arkansas Surgery Center
Pine Bluff

Dr. C.W. Jackson

Many years have passed and many changes have transpired since I began my practice of general medicine in the days prior to the implementation of Medicare.

As I look back on these early years, the practice of medicine was relatively uncomplicated, particularly for the new kid on the block. I chose a rural setting. All I needed was ample office space, enough credit to go in debt for medical equipment to suffice a self sufficient clinic, a trained nurse and an employee to serve as receptionist for the front office. The front office was really the least of my worries. There was very little medical insurance available and essentially no paper work. Any well educated high school graduate with typing and bookkeeping knowledge could fill the job description. All my energy was directed to the practice of medicine. Suddenly 1965 came into being and so did Medicare. The entire structure and purpose of the simple and quiet setting of the front office made a sudden and drastic change.

I have been asked to give my opinion as to why a trained medical assistant is important to my office. It is not just important; it is an absolute necessity from my viewpoint. With all the regulations now imposed and the mountain of paperwork necessary just to collect a simple charge for an office visit I could not successfully practice medicine without trained medical assistants.

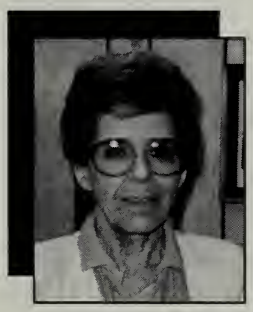
A medical doctor has always had the availability of trained nurses to hire but only recently has the trained medical assistant come into being. Many colleges and

Vo-Tech schools are now turning out students to fill this void. Once the training is complete a certification test is available for those students who desire to become a professional in the field of medical assisting. The certification program is made possible by the American Association of Medical Assistants with sponsorship by the American Medical Association. The AAMA is dedicated to the education and continued education of persons who choose to become involved in the field of paramedicals.

I can trust that my medical assistant knows how to handle all administrative duties just as my nurse knows how to handle all clinical duties. But better still a medical assistant can be trained to serve a dual role as many are certified clinically as well as administratively.

If you desire a fine tune to your medical practice hire a certified medical assistant. It will be one of the best investments and decisions you will ever make.

C.W. Jackson, M.D.
Judsonia


Marianne Jackson

What does it mean to me as medical doctor to have a medical assistant in my family practice office? This question was recently asked in my presence and now as I am hurried and anxious on my way to my office after an unexpected delay at the hospital, the question again surfaces to my conscious thinking. The best possible way this can be answered is by a simple list of questions and answers.

Q. I am running two hours late on my office schedule due to unexpected events at the hospital. I told Mrs. A on the telephone last night to come into my office at 10:00 a.m. today for a review of her medication in relation to her hypertensive problem. I forgot to alert my office. What will happen?

A. Mrs. A will come in as advised. My medical assistant knows just the right questions to ask this patient and will quickly assess the problem. By the time I arrive all medication will be listed on the patient's chart, current B/P and pulse taken and the patient will be comfortably waiting for my arrival.

Q. I left important mail to go out ASAP this morning. If it meets the deadline, it must be mailed early. Will this be done?

A. My medical assistant is always the first to arrive at my office and the last to leave. After she makes certain routine morning things are done such as coffee perked, charts pulled for day's schedule, computer lines cleared, mail opened and sorted, etc., she carefully checks for outgoing correspondence and makes certain all is in the mail by postal morning deadline. I might as well relax and gather my thoughts for my office schedule ahead of me. My medical assistant knows and does her job well.

Q. Today is the first of the month. Are checks written for payroll due today? They should have been written yesterday - distribution today.

A. Calm down, you may stop worrying about all these details my subconscious warns. Of course the checks are written, ready for distribution as soon as personnel arrives. My medical assistant keeps a daily calendar planner. She makes a plan for each day, and most important, she works the plan each day.

Q. Medicare called yesterday. They asked about a code number used on a specific claim. I could not answer the question. What happened? I forgot to ask my medical assistant. Am I going to get paid?

A. Of course you'll get paid I think to myself. My medical assistant will tell me this morning about the call and how the problem was solved. She definitely knows how to code and all the rules and guidelines of Medicare. She keeps a memo of such matters and each morning brings me up to date.

Q. Forgot! Yesterday was the 15th of the month. The day federal deposits were to be made to the IRS for my 941 forms. Did they get made? I will receive a stiff penalty if they are made late.

A. I have never yet been guilty of late filing. It is on my medical assistant's calendar planning pad. She always works her plan.

Q. Wonder if I have an emergency waiting for me? I feel a sense of uneasiness.

A. Of course I may have an emergency waiting for me. I am a family practice physician. It could be anything. My medical assistant is the first contact however, either in person or by phone, and she never fails me. She knows the right questions to ask. She knows how to evaluate the problem. She will know the correct procedure to follow. She can handle stress. She also knows her limitations and will contact me or the hospital by phone if the situation warrants.

Q. As a solo family physician in a rural setting I wonder if I should once again try to entice another medical doctor to join me as a practicing associate. I have had a

total of three at different times during my medical career only to see each leave for what they falsely believe to be greener pastures.

A. No, I really don't need another PA. I can manage my patient load but I can not practice medicine and handle all this paperwork and the details imposed by HCFA, state healthcare programs, Champus/Champva, CLIA, OSHA, nursing home requirements and whatever is next implemented. My answer is another well trained medical assistant. I will set my goals high and look for a certified medical assistant. I will begin by seeking help through our county chapter of the State Society of Medical Assistants. I can even get help on the national level through the American Association of Medical Assistants (AAMA). This will be money well spent. Also, I believe I'll tell my present certified medical assistant to make a memo to give herself a raise immediately. I can not afford to lose her.

As I park, ready to enter my office, I think again of the question, "What does a medical assistant mean to my medical practice and to me as a medical doctor?" The only real answer is you'll never know until you hire a trained medical assistant. Don't leave your office without one!

This article was written by a certified medical assistant after a memo from her doctor employer.

Marianne Jackson, CMA/AC
Judsonia

Dr. J.E. McDonald II

This year's Arkansas Society for Medical Assistant's president-elect, Cindy Smith, a Certified Ophthalmic Technician of our office, has benefited greatly from her experience in the ASMA. Her personal growth rewarded us all, and Cindy's overall knowledge of efficient office procedures has helped us refine our practices. Cindy also refined her interpersonal communication skills and gained a great deal of confidence through organizational activities locally and statewide. Her perspective on the field of Ophthalmology and practice of medicine widened as she established a statewide network of peers with similar interest. These attributes not only make Cindy a more valuable asset to our medical team, but they empowered her to care for our patients in a more professional manner.

The Arkansas Society of Medical Assistants serves an important purpose for many medical clinics around the state by providing the framework for continued education of medical assistants. I firmly believe that the better trained and educated a staff becomes, the quality of care increases for the patient. We applaud ASMA for its efforts in helping develop our staff over the years. Our clinic has underwritten the comparatively small cost for our assistants for many years and realized a large return on our investment through a more confident and knowledgeable staff.

I opened my ophthalmology practice in 1976, and saw patients in the traditional manner of minimal assistant contact and myself spending the majority of time during exams and office visits with the patient. As times have changed for the country and our practice, this became increasingly hard to do. I realized that my time was not being spent as productively as possible. We began to look for ways of becoming more efficient and increasing our quality of care.

It became apparent that an expanded role for the assistant would be the solution. With training, the productivity of myself, Cindy, and the office in general dramatically increased with no sacrifice of our high standards of care. My reliance on a well trained assistant has made me more effective and organized as a physician. I find that my patients are comfortable with seeking advice and support from our assistants, and have developed an excellent rapport with them as well. We have effectively reduced our cost of doing business while my time in the office is more productive and rewarding...doing the things that I do best. Over the years we have found that our most valuable assets are not our building or equipment, but our highly trained and motivated staff.

J.E. McDonald II, M.D.
McDonald Eye Associates, P.A.
North Hills Eye Center
Fayetteville

Cindy Smith

I have been a staff member for McDonald Eye Associates of Fayetteville for seven years. I am a certified ophthalmic technician. I have enjoyed my membership of the Arkansas Society of Medical Assistants for five years.

I am very proud to be a member of the Arkansas Society of Medical Assistants. This organization has been instrumental in my growth as a medical assistant. Due to the ASMA educational opportunities, I have expanded my knowledge and skills in all areas of a medical office. Participation in the meetings and holding offices on the local and state level has improved my ability to communicate, not only with the patients in our office, but with large groups of people also.

Being a member of ASMA allows our office to have a network of medical personnel all over the state and nation. This network includes physicians and their staff, insurance companies, office and surgical supply companies, and many other medical related personnel and companies. This network can be a vital support system for you and your staff.

Becoming a member of the Arkansas Society of Medical Assistants is one of the best decisions I have ever made. I would like to thank the physicians at McDonald Eye Associates, Drs. J.E. McDonald and Richard Harper, for their unending support in my endeavors to broaden my horizons as a medical assistant. I encourage all physicians to take the time and investigate ASMA. See what this organization can do not only for your staff, but also for you. Support your staff in their endeavors to become a member and possibly a certified medical assistant. Your investment will be returned tenfold.

Cindy Smith, CMA
McDonald Eye Associates, P.A.
North Hills Eye Center
Fayetteville

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I Know A Little Bit About A Lot of Things

J. Kelley Avery, M.D.*

A 46 year-old obese woman, married and the mother of two teen age children, presented to the attending, a general surgeon, with a five year history of "esophagitis." Eight years prior to this the patient had been told that a GI series showed an antral ulcer. She was treated with diet, antacids, and antispasmodics with some relief but not ever the complete cessation of symptoms.

The patient had numerous visits with the symptoms she attributed to "esophagitis." Several x-ray studies of the upper GI tract had failed to reveal pathology. The gall bladder had been studied several times and no pathology had been reported. She had an hemorrhoidectomy about five years before, and had been treated off and on for "depression" with various antidepressants and other psychotropic agents. During these years, she had treatment for "cystitis" and had been told that she had "mastitis." Throughout this time she continued to complain of epigastric burning which was attributed to "esophagitis."

About four years after the above encounter, the patient was admitted to the hospital in order to do further testing. Another upper GI series failed led to reveal fluoroscopic evidence of reflux. The attending surgeon did an endoscopic, EGD, examination. He reported "free regurgitation into the distal esophagus. Linear streaking in the distal 1/3 of the esophagus typical of esophageal inflammation." Aggressive treatment of the condition consisted of H2 blockers, antacids, elevation of the head of the bed, antispasmodics, and because the patient appeared depressed, tricyclic antidepressants were again prescribed. Another year followed with only intermittent relief of symptoms. Again numerous visits occurred with a multitude of complaints.

About a year later the attending surgeon consulted a gastroenterologist in a nearby medical center. The consultant repeated the EGD examination. Some reflux was noted, however, there was no visible esophageal pathology. There did appear to be some inflammation in the stomach and duodenum. A biopsy of the stomach revealed some "chronic inflammation."

The complaints continued despite more treatment with all the drugs previously used with little or no relief. Again, the visits were frequent and the complaints were multiple.

One year later the patient was admitted to the hospital in her home town complaining of a "burning substernal pain." A thorough cardiac workup was

* Dr. Avery is chairman of the Loss Prevention Committee at State Volunteer Mutual Insurance Company in Brentwood, Tennessee and medical director of Ambulatory Services at St. Thomas Hospital in Nashville, Tennessee.

negative. Another EGD was done. This time a "gastric ulcer" was found and a biopsy was negative for malignancy. Propanalol was added to the regimen because of the chest pain. month later, because of continued complaints, antidepressants were again prescribed.

One month after this visit the patient was seen by her attending surgeon. The office record revealed "patient decided to have a repair of her hiatal hernial." The attending's note followed, "patient sick in the head." Although "hiatal hernia" was found in one of the earlier studies, it had not been a prominent finding. It must be assumed that the attending had attributed the symptoms of reflux to the hernia, or, perhaps because she was "sick in the head."

The patient was admitted to the hospital and a type of fundal plication was done. The operative record described "hiatus admits four fingers," states that the routine abdominal exploration was negative, and described the procedure. During the dissection of the gastro-hepatic ligament, serious bleeding was encountered requiring six units of blood. Deep sutures were required to control the bleeding. The spleen was lacerated during the procedure and repaired. The patient appeared to be doing well when she was taken to the recovery room about six hours after the case began. She reacted from the anesthesia appropriately and went to the SIU.

The first post operative day the patient had fever to 101, tachycardia, and an elevated WBC. She was examined and found to have significant lower abdominal tenderness. She continued to have fever which was treated empirically. Within three days following the surgery with continuing fever, she became edematous and dyspneic, and evidence of renal failure developed. She was then transferred to the Medical Center in a nearby city.

The same day of transfer, the patient was taken to the OR where at exploration the line of anastomosis had disrupted and there was a fulminant peritonitis with copious amounts of gastric secretions present. The dyspnea progressed and ARDS was apparent. Renal function continued to deteriorate requiring dialysis. Long and heroic efforts were made to save this patient but she expired some eight weeks after the first surgery.

In the Medical Center, the record first contains the history of an extremely unhappy life. There had been a bad marriage for years, the teenagers had given their mother much trouble, and the family income depended on the factory job held by the patient until about two months before her death.

Loss Prevention Considerations

The study of this very long and complicated record revealed a general level of care which seemed to be below the standard. The adequate consideration of this patient's social and psychiatric history was never a part of the picture. In retrospect, one could conclude that the frequent visits and multiple complaints literally cried out for someone to look at the whole picture.

The patient "decided to have repair of her hiatal hernia." Multiple studies produced inconsistent findings. The effects of prolonged stress on the GI Tract are well known, but were not adequately considered in this case, and except for the demeaning remark, "sick in the head," we have little indication that the attending ever seriously considered this very important part of this patient's picture.

The surgical procedure at the community hospital was difficult to defend in at least two areas. The stomach was transsected very close to the esophasogastric junction not leaving the customary cuff of stomach in order to secure a better anastomosis. The decision to repair the spleen rather than remove it in the face of this very long and bloody operation was the subject of criticism by expert witnesses on the plaintiff side and a fact that defense marginal. With evidence of some intra-abdominal complication as evidenced by the fever, the lower abdominal tenderness, the tachycardia and generally deteriorating condition, most of the reviewers felt that the delay of four days was very likely a contributing factor to this patients death. Another area of criticism by expert reviewers was the fact that the attending surgeon had not done a pyloroplasty and vagotomy to aid in stomach emptying in this patient.

And, if that was not enough, the attending surgeon left town the day after surgery without informing either the patient or her family.

This patient presented great difficulties to the attending physician. She was truly a difficult and demanding case. It appeared that the reasoning went something like this; "I think I know what's wrong with her, but the evidence is inconsistent. I don't know how to treat her - I've tried everything I can think of, so let's operate." The poorest of all choices! Get expert help with the "depression" - Yes! Refer her to the medical center for management help and not for "rule out or rule in." A teacher of mine used to tell us, "Any dim wit doctor can treat the straight forward case, but it takes a real doctor to diagnose and manage the patient with this kind of psychosomatic overlay."

Taking all the above into consideration, the only factor that made this case impossible to defend under any circumstances was the remark "sick in the head." This remark would have provided the jury with ample room to conclude that the attending didn't know what was wrong with his patient, really thought she was a mental case; but operated on her anyway! A six figure settlement closed the books on this tragic story. We doubt that the books will ever be really closed on this case in the mind and heart of the attending surgeon. ■

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Arkansas HIV/AIDS Report 1983-1992

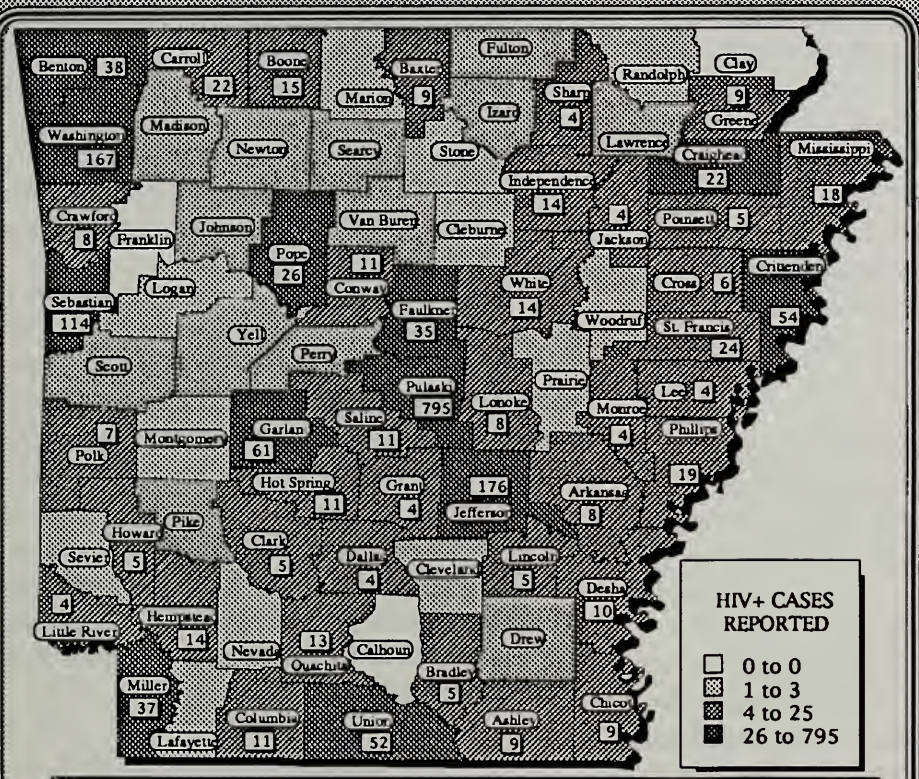
Arkansas: June 1983 through August 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	438	421	254	1,680	85.37
	Female	1	1	6	27	39	71	89	54	288	14.63
AGE	< 5	0	0	1	1	2	9	14	4	31	1.58
	5-12	0	0	0	1	1	5	2	0	9	0.46
	13-19	0	0	0	8	8	14	20	21	71	3.61
	20-29	8	10	15	109	125	192	153	108	720	36.59
	30-39	7	15	22	86	105	206	219	119	779	39.58
	40-49	8	7	11	24	35	61	73	37	252	12.80
	> 49	1	1	6	6	12	19	23	18	86	4.37
	Unknown	0	0	0	8	2	3	6	1	20	1.02
RACE	White	16	24	47	171	178	353	311	183	1,283	65.19
	Black	4	9	8	70	107	153	195	119	665	33.79
	Other	0	0	0	2	5	3	4	6	20	1.02
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	308	1,968	100%

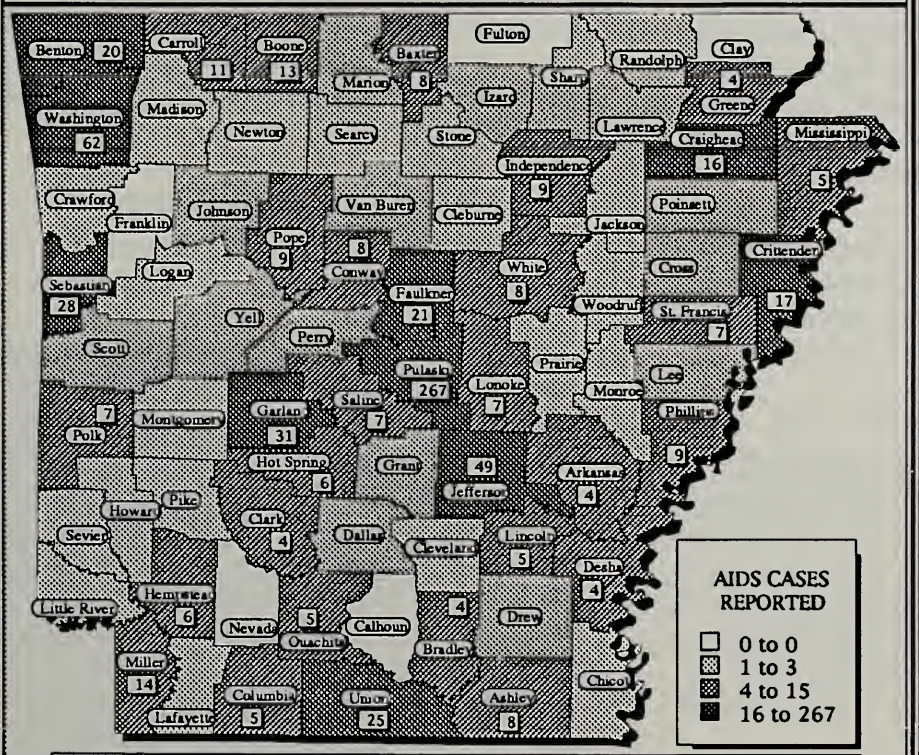
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	125	703	89.44
	Female	1	0	4	6	10	20	25	17	83	10.56
AGE	< 5	0	0	0	1	1	6	6	1	15	1.91
	5-12	0	0	0	1	0	1	1	0	3	0.38
	13-19	0	0	0	0	0	4	3	1	8	1.02
	20-29	7	9	15	27	24	55	57	40	234	29.77
	30-39	3	13	23	36	41	78	80	61	335	42.62
	40-49	1	6	8	10	7	35	41	26	134	17.05
	> 49	1	0	4	8	7	11	13	13	57	7.25
RACE	White	9	22	43	61	58	141	134	98	566	72.01
	Black	3	6	7	20	21	47	66	42	212	26.97
	Other	0	0	0	2	1	2	1	2	8	1.02
RISK	Male/Male Sex	7	17	31	59	50	118	118	82	482	61.32
	Injection Drug User (IDU)	0	2	10	4	11	18	28	19	92	11.70
	Male/Male Sex & IDU	3	9	4	6	6	18	17	10	73	9.29
	Heterosexual	2	0	2	3	6	10	10	12	45	5.73
	Transfusion	0	0	2	7	3	7	11	3	33	4.20
	Perinatal	0	0	0	1	1	6	6	1	15	1.91
	Hemophiliac	0	0	0	1	1	5	5	2	14	1.78
	Undetermined	0	0	1	2	2	8	6	13	32	4.07
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	142	786	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 1,968 Arkansans have been reported to be HIV+ as of August 25, 1992.



A total of 786 Arkansans have been diagnosed with AIDS as of August 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

BENTON

Harper, Donald A., Radiology. Born, 7/11/53. Medical education, Uniformed Services University of the Health Sciences, Bethesda, MD, 1982. Internship, UA Naval Hospital, Bremerton, WA, 1983. Residency, National Naval Medical Center, Bethesda, MD, 1989. Board certified.

DEQUEEN

Fotopoulos, Chris K., General Surgery. Born, 10/2/37. Medical education, Creighton School of Medicine, Omaha, NE, 1960. Internship, St. Catherine's. Residency, Truman Medical Center, 1966. Board eligible.

EL DORADO

Bryant III, D'Orsay D., Orthopaedic Surgery. Born, 4/22/58. Medical education, Howard University College of Medicine, Washington, D.C., 1985. Internship/residency, Howard Hospital, 1991.

FORT SMITH

Ahmed, Sahibzada A., General Surgery & Endoscopy. Born, 9/4/46. Medical education, Dacca Medical College, Dacca, Bangledesh, 1970. Internship, Catholic Medical Center, 1976. Residency, Methodist Hospital, 1980. Board certified.

Borklund, Patty K., Family Practice. Born, 10/1/48. Medical education, Kirksville College of Osteopathic Medicine, MO, 1989. Internship, Tulsa Regional Medical Center, 1990. Residency, Oklahoma State University College of Osteopathic Medicine, Tulsa, 1992. Pending certification.

Diment, David D., Radiology. Born, 1/18/60. Medical education, University of Oklahoma, Oklahoma City, 1984. Internship, University of Oklahoma, 1985. Residency, Baylor College of Medicine, 1989. Board certified.

Floriun, Thomas F., Rehabilitation. Born, 2/16/51. Medical education, Eastern Virginia Medical School, 1988. Internship, Eastern Virginia Medical School, 1989. Residency, Medical College of Virginia, 1992. Board eligible.

Harris, Shirley D., Anesthesiology. Born, 11/3/60. Medical education, Meharry Medical College, 1986. Internship, Methodist Hosptial, 1987. Residency, UMDNJ-Robert Wood Johnson Hospital, 1991. Pending certification.

Hodge, Trevor J., Internal Medicine. Born, 4/22/53. Medical education, Hahnemann University, Philadelphia, PA, 1985. Internship, Brwn Mawr Hospital, PA, 1986. Residency, Hahnemann University, 1988.

Little, Charles A., Anesthesiology. Born, 1/10/55. Medical education, University of Osteopathic Medicine & Health Sciences, Des Moines, IA, 1988. Internship/residency, Medical College of Wisconsin, 1992. Pending certification.

Marvel, Patty M., Psychiatry. Born, 9/18/45. Medical education, University of Texas Medical School, Houston, 1986. Internship/residency, Baylor College of Medicine, 1991.

Seiter, Kenneth P., Anesthesiology. Born, 6/8/50. Medical education, Oklahoma State University College of Osteopathic Medicine, Tulsa, 1987. Internship, Tulsa Regional Medical Center, 1988. Residency, University of Tennessee Medical Center, Memphis, 1992.

HOT SPRINGS

Little, John E., Anesthesiology. Born, 9/16/62. Medical education, University of Texas, San Antonio, 1988. Internship/residency, University of Missouri, Columbia, 1992. Board eligible.

JACKSONVILLE

Hamer, Richard A., Neurology. Born, 9/21/57. Medical education, University of Alabama, Birmingham, 1985. Internship, University of Alabama, 1986. Residency, Parkland SWMC, Dallas, TX, 1989. Board eligible.

JONESBORO

Braden III, Terence P., Physical Medicine & Rehabilitation. Born, 6/29/58. Medical education, University of Medicine and Dentistry of New Jersey - Osteopathic Medicine, Stratford, NJ, 1985. Internship, Kennedy Memorial Hospital, University Medical Center, 1986. Residency, Emory University, Atlanta, GA, 1992. Board eligible.

Burns, Robert B., Internal Medicine. Born, 2/13/59. Medical education, UAMS, 1985. Internship, University of Birmingham, AL, 1986. Residency, Montgomery Internal Medicine Residency, Birmingham, 1987; Baptist Memorial Hospital, Memphis, TN, 1989. Board certified.

Stilson, Rebecca A., OB/GYN. Born, 10/12/57. Medical education, Ohio State University, Columbus, 1988. Internship/residency, University of Tennessee, Memphis, 1992.

LITTLE ROCK

Abraham III, James H., Internal Medicine. Born, 5/12/60. Medical education, UAMS, 1987. Internship, UAMS, 1990. Residency, New England Medical Center, Boston, MA, 1992. Board certified.

Bishop, Elisabeth M., Internal Medicine. Born, 11/9/60. Medical education, UAMS, 1989. Internship/residency, UAMS, 1992.

Bowden, Phillip R., Gastroenterology. Born, 1/12/60. Medical education, UAMS, 1987. Internship/residency, UAMS, 1990. Fellowship, University of Tennessee, Memphis, 1992.

Melhorn, Virginia B., Pediatrics/Internal Medicine. Born, 3/26/49. Medical education, UAMS, 1986. Internship/residency, UAMS & Arkansas Childrens Hospital, 1990. Board certified.

Montanez, Josue, Radiology. Born, 10/23/56. Medical education, University of Texas Medical School, San Antonio, 1983. Internship/residency, University Hospital of Cleveland, OH, 1988. Board certified.

Nowlin, James B., Anesthesiology. Born, 11/17/52. Medical education, UAMS, 1988. Internship/residency, UAMS, 1992. Board eligible.

Nugent, Richard R., General Preventive Medicine. Born, 4/27/40. Medical education, University of Pennsylvania, Philadelphia, 1966. Internship, Lankenau Hospital, Philadelphia, PA, 1967. Residency, University of Vermont Medical Center, Burlington, 1972; University of North Carolina, Chapel Hill, 1976. Board certified.

Schlesinger, Scott M., Neurosurgery. Born, 9/23/60. Medical education, UAMS, 1986. Internship/residency, Southwestern Medical School, Dallas, TX, 1992.

Schmitz, Michael L., Pediatric Anesthesiology. Born, 6/13/60. Medical education, University of California, San Francisco, 1986. Internship/residency, Harbor-UCLA Medical Center; University of Pennsylvania, 1992. Board certified.

Smith, Samuel D., Pediatric Surgery. Born, 8/20/55. Medical education, UAMS, 1980. Internship, UAMS, 1981. Residency, UAMS & Children's Hospital Medical Center, Boston, MA, 1985. Board certified.

Stewart, Daryl A., General Surgery. Born, 1/21/61. Medical education, University of Texas Science Center, San Antonio, 1987. Internship, Marcopa Medical Center,, Phoenix, AZ, 1989. Residency, Akron General Medical Center, Akron, OH, 1992.

Walker, Lee W., Internal Medicine. Born, 2/1/59. Medical education, Meharry Medical College, 1987. Internship/residency, Staten Island University Hospital, 1990. Board eligible.

MARIANNA

Webber, David L., Family Practice. Born, 8/16/56. Medical education, West Virginia School of Osteopathic Medicine, Lewisburg, 1988. Internship, Muskegon General Hospital, MI, 1989. Residency, Medical College of Ohio, Toledo, 1991.

NORTH LITTLE ROCK

Lawson, William B., Psychiatry. Born, 11/27/45. Medical education, University of Chicago, IL, 1978. Internship/residency, Stanford University. Board certified.

Owen Jr., Richard R., Psychiatry. Born, 7/8/58. Medical education, University of Minnesota Medical School, Minneapolis, 1984. Internship/residency, McLean Hospital, Belmont, MA, 1988. Board certified.

Talbert, Gary E., Plastic & Reconstructive Surgery. Born, 3/2/57. Medical education, UAMS, 1984. Internship, UAMS, 1989. Residency, University of Kentucky, Lexington, 1991. Board certified.

PARAGOULD

Jackson, Ron E., Preventive/Occupational. Born, 5/20/44. Medical education, UAMS, 1972. Internship, William Beaumont Army Medical Center, El Paso, TX, 1973. Residency, Harvard School of Public Health, Boston, MA, 1977. Board certified.

PINE BLUFF

Clark, Charles A., Orthopaedics. Born, 2/12/50. Medical education, University of South Carolina School of Medicine, Columbia, 1981. Internship, University Medical Center Hospital, Burlington, VT, 1982. Residency, Wilford Hall, USAF Medical Center, San Antonio, TX, 1988. Board certified.

ROGERS

Boden, Donna J., Pathology. Born, 1/1/55. Medical education, University of Texas, Houston,

1987. Residency, University of Texas, Houston, 1991. Fellowship, University of Texas, Galveston, 1992.

SEARCY

White, William M., Radiology. Born, 2/14/61. Medical education, UAMS, 1983. Internship, University Hospital, 1988. Residency, University of Texas Medical Branch, Galveston, 1992. Board certified.

TEXARKANA

Clardy, James A., Psychiatry. Born, 8/21/58. Medical education, UAMS, 1986. Residency, UAMS & National Institute of Mental Health, 1991.

OUT-OF-STATE

Growney, John T., Family Practice, Atchison, KS. Born, 6/27/37. Medical education, Creighton, Omaha, NE, 1963. Internship, 1964. Board certified.

Roundtree, Susan D., Neurology. Born, 8/18/51. Medical education, UAMS, 1979. Internship, St. Paul Ramsey Hospital, MN, 1980; UAMS, 1988. Residency, UAMS, 1990; Baylor, 1991. Board certified.

RESIDENT PHYSICIAN SECTION

Atkin, Stuart R., Anesthesiology. Born, 3/8/55. Medical education, St. George's University School of Medicine, Grenada, West Indies, 1990. Internship, Episcopal Hospital, Philadelphia, PA; St. Mary's Hospital, Waterbury, CT. Residency, UAMS.

Bonetti, Juan M., Pediatrics. Born, 7/8/58. Medical education, Medical College of Georgia, Augusta, 1990. Internship/residency, UAMS; Arkansas Children's Hospital.

Colomb, Carville M., Pediatric Anesthesiology. Born, 5/7/62. Medical education, Louisiana State University Medical Center, New Orleans, 1988. Internship/residency, University of Texas Southwestern, Dallas.

Govindarajan, Rangaswamy, Internal Medicine. Born, 6/11/56. Medical education, Mysore Medical College, Karnataka, India, 1980. Internship, Mysore Medical College. Residency, UAMS.

Hawkins, Andrew F., Pediatrics. Born, 6/4/64. Medical education, University of Tennessee, Memphis, 1991. Internship/residency, UAMS.

Hawkins, Diane S., Psychiatry. Born, 1/12/65. Medical education, University of Tennessee, Memphis, 1991. Internship/residency, UAMS.

Hubach, Cindy A., Family Practice. Born, 2/9/64. Medical education, UAMS, 1992. Residency, UAMS.

Martin Jr., Robert H., Family Practice. Born, 9/11/65. Medical education, UAMS, 1992. Residency, AHEC, Pine Bluff.

Kuykendall, Scott P. Born, 5/26/62. Medical education, UAMS, 1992.

Rosa, Regina. OB/GYN. Born, 10/5/65. Medical education, UAMS, 1991. Internship/residency, University Hospital, Little Rock.

Velusamy, Muthusamy, Internal Medicine. Born, 5/10/62. Medical education, Stanley Meidcla College, Madras, India, 1985. Internship, Stanley Hospital. Residency, UAMS.

MEDICAL STUDENTS

Duncan, Thomas J.

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Radiological Case of the Month

Steven R. Nokes, M.D.
James R. Adametz, M.D.

History:

This 44-year-old male presented with a headache and left-sided weakness. An MR scan of the brain, and conventional and MR carotid angiograms were obtained.

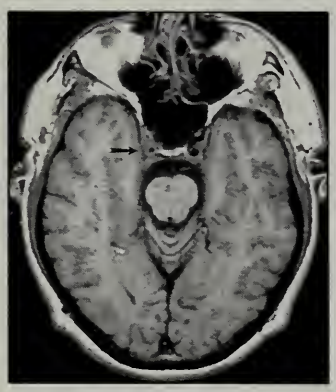

Figure 1. Axial T_1-weighted image of the head.

Figure 2. Axial T_1-weighted contrast-enhanced image.

Figure 3. MR carotid arteriogram.

Figure 4. Conventional carotid arteriogram.

Spontaneous Internal Carotid Artery Dissection

Findings:

The post-contrast T_1-weighted scan reveals gyral enhancement in the distribution of the right middle cerebral artery consistent with subacute ischemia (Figure 2). Asymmetry of the carotid arteries is shown on the pre-contrast scan at the level of the cavernous sinus reveals (Figure 1). The right internal carotid artery is small with a peripheral ring of increased signal (arrow). The MR and conventional angiograms demonstrate smooth tapering of the right internal carotid artery (arrows). The conventional study reveals occlusion of the supraclinoid carotid as well.

Discussion:

Spontaneous dissection of the internal carotid artery is an uncommon, but not rare event, that is a cause of stroke in young adults. It typically presents in the second to fifth decade, whereas atherosclerotic disease and fibromuscular dysplasia affect patients beyond the fifth decade. The diagnosis is suggested by associated ipsilateral frontal headaches, Horner syndrome and neck pain. The prognosis is controversial in the literature.

The clue to the diagnosis in this case is the abnormal appearance of the carotid siphon on standard spin-echo MR images, which signifies significant carotid disease. Abnormal MR flow patterns require at least a 90% stenosis of the cervical carotid. The presence of normal flow does not reliably exclude significant disease, however. A bright signal ring within the artery on MR is indicative of intramural hemorrhage with dissection.

Various techniques have been applied to obtain noninvasive MR angiograms with resolution approaching high-quality digital subtraction angiography. Both techniques demonstrate the classic findings of ICA dissection, but the supraclinoid occlusion was only evident on the conventional exam. A tapered stenosis occurs in 50%; with an associated aneurysm in 28% and occlusion in 18%. An isolated dissecting aneurysm occurs in 7% of cases. Intracranial emboli occur in 15% of patients. Dissections often resolve, sometimes progress, and rarely recur. The ICA is the site of predilection, although the vertebral and common carotids are affected. Patients are treated with anticoagulants unless follow-up studies demonstrate extension of hemorrhage.

Acknowledgement

We would like to thank Marjorie Hammons for preparing the manuscript.

References

1. Houser WO, Mokri B, Sundt Jr. TM, Baker Jr. HL, Reese DF. Spontaneous cervical cephalic arterial dissection and its residuum: angiographic spectrum. AJNR, 1984; 5:27-34.

2. Brant-Zawadzki M. Routine MR imaging of the internal carotid artery siphon: angiographic correlation with cervical carotid lesions. AJNR, 1990; 11:467-71.

3. Heinz RE, Yeates AE, Djang WT. Significant extracranial carotid stenosis: detection on routine cerebral MR images. Radiology, 1989; 170:843-48.

4. Wagle WA, Dumoulin CL, Souza SP, Cline HE. 3DFT MR angiography of carotid and basilar arteries. AJNR, 1989; 10:911-19.

Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.

Contributor: James R. Adametz, M.D. is affiliated with Neurosurgical Associates in Little Rock.

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AMS Newsmakers

Dr. David Burnette, a family practioner from Mountain View, has been named the "Humanitarian of the Year" by the Arkansas Osteopathic Medical Association.

Dr. Burnette was recognized for his volunteer work for the underprivileged children in the state of Arkansas. He has also helped underprivileged and homeless children through missionary work in Haiti and New Guinea.

Dr. Roger Cagle, a family practioner from Paragould, was recently installed as director of the Arkansas Academy of Family Physicians. Dr. Cagle is a delegate to the Arkansas Medical Society.

Dr. Richard Daily, an emergency medicine physician associated with Cooper Clinic in Fort Smith, has been declared a Diplomate of the American Board of Emergency Medicine.

Dr. Gary Edwards, a family practioner from Fort Smith, was named "Physician of the Year" by the Arkansas Osteopathic Medical Association.

Dr. Martin Fiser, an allergist associated with the Arkansas Allergy Clinic in Little Rock, was recently elected president of the American Lung Association of Arkansas.

Attending the recent annual meeting of the Southern Orthopaedic Association held in Whistler, British Columbia were: Dr. and Mrs. Peter Irwin of Fort Smith; Dr. and Mrs. Banks Blackwell of Pine Bluff; and, Dr. Ted Honghiran and his daughter. Dr. Blackwell is the SOA councilor for Arkansas.

Dr. Randy Jordan, a cardiologist from Little Rock, was recently elected president of the Arkansas Affiliate of the American Heart Association.

Dr. Jerry Stewart, a pulmonologist associated with Cooper Clinic of Fort Smith, has been appointed medical director of the ventilator independent program at Fort Smith Rehabilitation Hospital.

Dr. Brian Sudderth, a family physician from Bryant, has been named the chief of staff at Saline Memorial Hospital.

Dr. Robert White, an internist from Paragould, was recently elected vice president of the Arkansas Affiliate of the American Heart Association.

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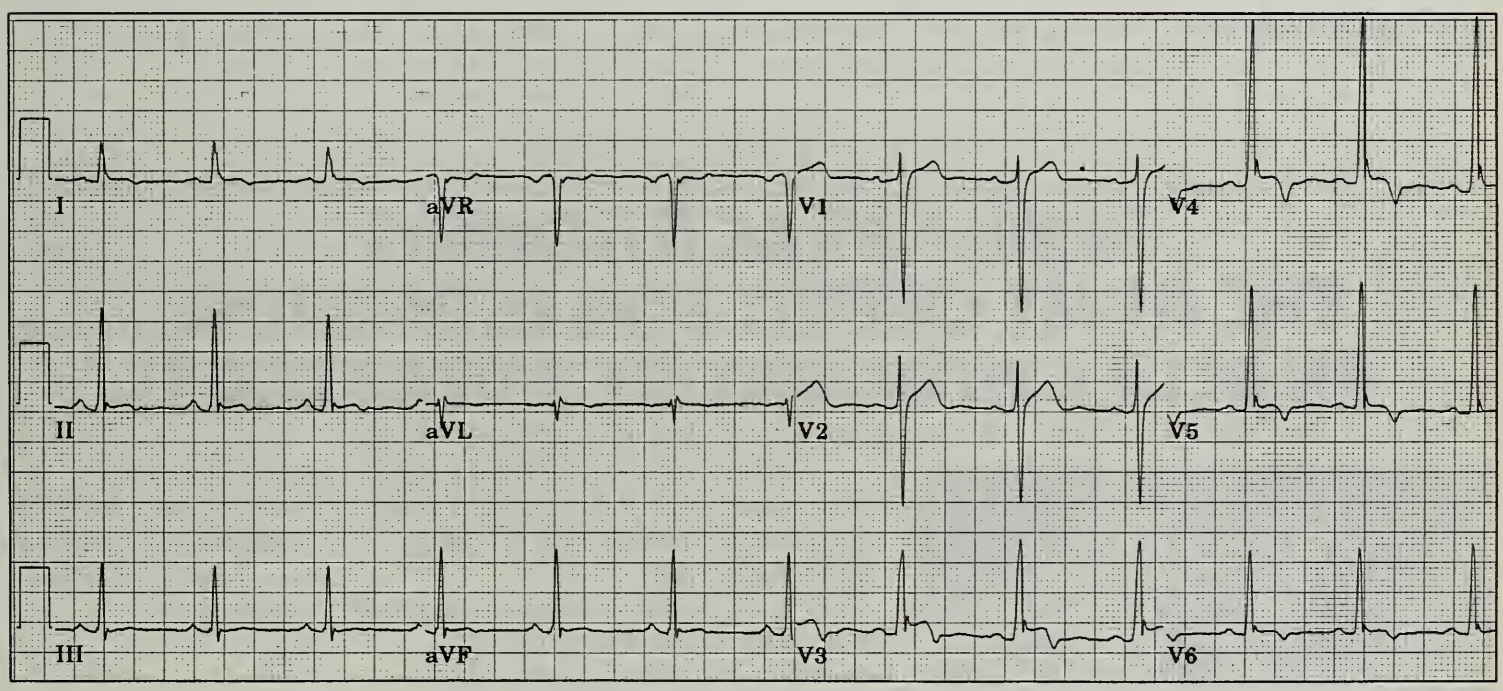
Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

This record was obtained from a 35-year-old male with a history of chest pain.



DISCUSSION:

Normal sinus rhythm is present with normal AV and intraventricular conduction. Voltage criteria for LVH are present in the precordial leads, but not aVL: the significance of this observation in people less than 40 years is suspect. The most striking abnormality is ST segment elevation and T wave inversion noted in leads V3-V6. In isolation, these findings might suggest either resolving pericarditis or evolving myocardial infarction. Several features make these diagnoses suspect. First, the absence of sinus tachycardia and diffuse ST segment elevation or PR segment shifts in other leads go against the diagnosis of acute pericarditis. Secondly, the pattern was stable over a period of days, further suggesting that the ST segment elevation did not represent acute injury.

The electrocardiographic diagnosis of benign early repolarization variant is suggested by the presence of notching in the terminal portion of the QRS leading into elevated ST segments which are concave upwards. T wave inversion is relatively uncommon in the early repolarization variant and has been noted primarily in young black men. Similar patterns may be noted in highly trained athletes. The depth of this inversion may be affected by a number of variables including hyperventilation and alterations in serum potassium. In all cases, clinical correlation is required for correct interpretation of this ECG pattern. Echocardiography may be helpful in determining the presence of left ventricular hypertrophy which may produce a similar pattern.

In Memoriam

Eugene Thomas Ellison Sr., M.D.

Dr. Eugene T. Ellison Sr., of Texarkana, Tex., died Tuesday, August 25, 1992. He was 81.

Dr. Ellison was a Founding Fellow of the College of Obstetrics and Gynecology, professor and chairman of the Obstetrics and Gynecology Department at the University of Arkansas Medical School. He was former chief of staff at Wadley Regional Medical Center and St. Michael Hospital. Dr. Ellison was a member of the Arkansas Medical Society, the American Medical Association, the Southern Medical Association, and was Arkansas chairman of the American College of Surgeons.

Survivors are a son, Dr. Eugene T. Ellison Jr. of Texarkana; a daughter, Mary (Bunny) Becker of San Antonio; and six grandchildren.

C. Yulan Washburn, M.D.

Dr. C. Yulan Washburn, a retired physician from Ward, died Wednesday, August 19,1992. He was 79.

Dr. Washburn was a member of the Fifty Year Club of the Arkansas Medical Society.

Survivors are his wife, Maxine Galloway Washburn; two sons, Steve Washburn of Tombston, Ariz. and Dennis Y. Washburn of Monroe, N.C.; a daughter, Gina Washburn Spence of Raliegh, N.C.; a sister, Sara W. McSwaim of Shelby, N.C.; and one grandchild.

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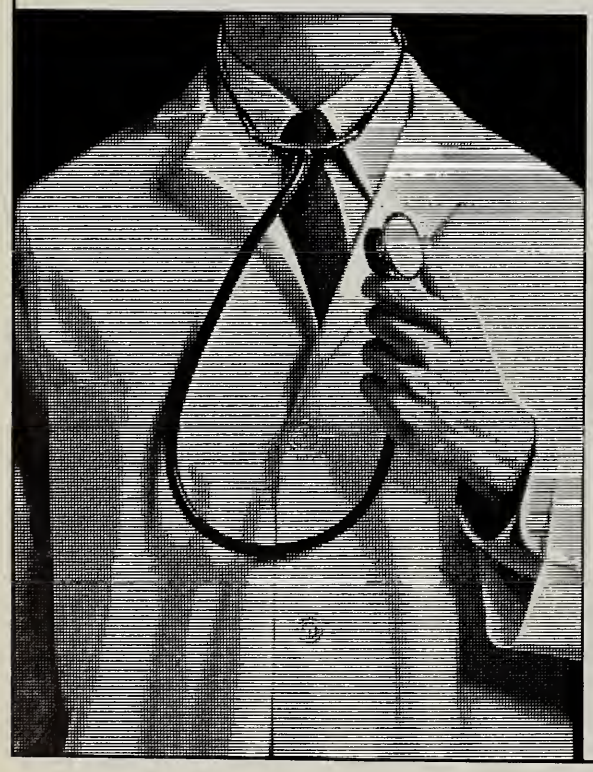

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Resolution

Edgar J. Easley, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of their respected colleague, Edgar J. Easley, M.D.; and

Whereas, he was a loyal member of this organization for over 50 years, giving freely of his time and effort to numerous leadership positions including the office of President in 1951; and

Whereas, Dr. Easley's concern for the health and well-being of the citizens of this state was manifested by his many years of service as Assistant Health Officer of the Arkansas Department of Health; be it therefore

RESOLVED, that this resolution be adopted and placed among the permanent archives of this Society; and

RESOLVED, that a copy of this resolution be forwarded to Dr. Easley's family as a token of our sincere sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
August 19, 1992

By Order of the Memorials Committee
Bruce E. Schratz, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

James H. Growdon, M.D.

Whereas, the members of the Pulaski County Medical Society are saddened by the recent death of their respected colleague, James H. Growdon, M.D.; and

Whereas, Dr. Growdon served this organization faithfully for over 40 years; and

Whereas, his devotion to his patients, his profession, and his students at the University of Arkansas College of Medicine will be long remembered; be it therefore

RESOLVED, that this resolution be adopted and stored in the permanent records of this Society; and

RESOLVED, that a copy be sent to Dr. Growdon's family as a demonstration of our sincere sympathy; and

RESOLVED, that a copy be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
August 19, 1992

By Order of the Memorials Committee
Bruce E. Schratz, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

Robert R. Matthews, M.D.

Whereas, the membership of the Pulaski County Medical Society notes with sincere sadness the recent death of an esteemed colleague, Robert R. Matthews, M.D.; and

Whereas, his dedication to his chosen profession of psychiatry, as evidenced by long years of service to this Society and to the Arkansas State Hospital, was widely acknowledged; and

Whereas, Dr. Matthews' concern for the health and well-being of the citizens of this state was manifested by his many years of service as Assistant Health Officer of the Arkansas Department of Health; be it therefore

RESOLVED, that this resolution be adopted and be made part of the permanent records of this Society; and

RESOLVED, that a copy of this resolution be mailed to Dr. Matthews' family as an expression of our heart-felt sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
August 19, 1992

By Order of the Memorials Committee
Bruce E. Schratz, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

Medicine in the News

Health Care Access Foundation Update

As of September 1, 1992, the Arkansas Health Care Access Foundation has provided free medical service to 468 medically indigent persons, received 9641 applications, and enrolled 20173 persons.

The program has 1504 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

UAMS Mammography Center Reaccredited

The Mammography Program of the Ambulatory Care Diagnostic Center, in conjunction with the UAMS Department of Radiology, has earned renewal of its coveted accreditation by the American College of Radiology (ACR). Wilma C. Diner, M.D., is the director of Mammography at UAMS Medical Center.

Ray W. Leavelle, M.D. Scholarship Fund Established

The Ray W. Leavelle, M.D. Scholarship Fund has been established at St. Michael Hospital with an initial gift of $10,000. The late Dr. Leavelle was a former employee at Howard Memorial Hospital in Nashville.

Each year, a scholarship will be awarded to the outstanding senior radiologic technology student enrolled in the Radiological Technology Program conducted at St. Michael in conjunction with the University of Arkansas for Medical Sciences and the Area Health Education Center, according to Joe Robbins, M.D., chief of radiology at St. Michael Hospital.

The memorial scholarship fund was established to recognize and honor the contributions made by the late Dr. Leavelle to the Radiologic Technology Program and St. Michael Hospital. Dr. Leavelle was instrumental in bringing the radiologic school to Texarkana.

Persons interested in memorializing Dr. Leavelle may make contributions to the Ray W. Leavelle, M.D. Scholarship Fund, c/o St. Michael Hospital, PO Box 1140, Texarkana, AR 75502.

ASIM Applauds Vote Restoring Payment for EKG Interpretation

The American Society of Internal Medicine (ASIM) recently praised the House of Representatives for passage of legislation that would restore Medicare payments for the interpretation of electrocardiograms (EKGs) without increasing federal expenditures.

EKG interpretation, according to ASIM Executive Vice President Alan R. Nelson, M.D., is as important as the test itself. "An EKG is an invaluable tool in detecting heart disease, but it is little more than a piece of paper if not interpreted by a trained physician," said Dr. Nelson.

As the specialty that treats more Medicare patients than any other, the internist represented by ASIM see first-hand the detrimental effect on their patients of the prohibition on Medicare payments for the interpretations of EKGs. Dr. Nelson said many internists report to ASIM that the only way to get EKGs interpreted for their patients is to refer them for a complete medical consultation resulting in greater patient cost and inconvenience.

UAMS Ophthalmology Department Recipient of Bequest

The Ophthalmology Department at the University of Arkansas for Medical Sciences and the Lions World Services for the Blind are recipients of a bequest totalling $1,700,000. The source of the bequest was the estate of Charles Eickhoff, a native of Little Rock.

It was the wish of Mr. Eickhoff to bequeath his entire estate equally to the two organizations. One half of the estate was directed to the University of Arkansas for Medical Sciences Foundation Fund, in Little Rock, for use by the Ophthalmology Department for eye research, education and development.

An equal portion of the Eickhoff estate is directed to the endowment fund of Lions World Services for the Blind in Little Rock, to perpetuate rehabilitation services for emotional adjustment to blindness, skills training in independent living, communication and travel, as well as vocational training for a productive life. Mr. Eickhoff also expressed an interest in the Low Vision Clinic with vision rehabilitation services and electronic aids training for both resident trainees and outpatients.

Topics in Search of Authors

You can influence your peers - and give something back to your profession - if you plan to write an article for *The Journal of the Arkansas Medical Society*.

The Journal needs your thoughts and ideas. So why not consider putting your expertise on paper? Here are some of *The Journal's* topics in search of an author.

- Enhancing the doctor-patient relationship
- Practice management for today's physicians
- Women's health issues
- Teens and drug use
- A smokeless society
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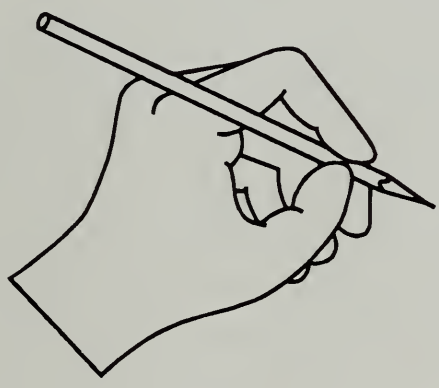
- What's the value of organized medicine?
- New treatments and technology
- Physician stress, emotions, health
- Medicare/Medicaid issues
- Medical history of Arkansas
- A doctor's hobby
- Medicine of the future
- Improving the physicians' image
- How to market your practice
- New treatments from Arkansas' medical facilities
- Coping with difficult patients



For more details, call or write:
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Things To Come

October 26-29

Primary Care Update. Riviera Hotel and Casino, Las Vegas, NV. Sponsored by Interstate Postgraduate Medical Association of North America. CME Category I credit hours available. Fees: $225.00, registration before October 1; $275.00, registration between October 1-21; $325.00, registration after October 21; $50.00, residents, interns, allied health professionals. For more information, call (608) 257-1401.

October 30

3rd Annual Rush Symposium on Hepatic and Biliary Disease. Sponsored by and held at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL. For more information, call Suzanne Buss at (312) 942-6242.

October 30-31

Americans with Disabilities Act Compliance Seminar. New York Hilton and Towers. Sponsored by the American College of Occupational and Environmental Medicine, Arlington Heights, IL. For more information, call Kay Coyne or Marianne Dreger at (708) 228-6850, ext. 18.

October 31

Recognition and Management of Parkinson's Disease for the Primary Care Physician. Holiday Inn Crowne Plaza, Kansas City, MO. Sponsored by the Department of Neurology, University of Kansas Medical Center. AMA Category I and American Academy of Family Physicians credit hours available. Fees: $40.00, physicians; $25.00, residents/full-time students. For more information, call Mary Boyd at (913) 588-4488.

November 5-8

ISACB 3rd Biennial Meeting: Toward Application of Advances in Basic Cardiovascular Biology. Adam's Mark Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine, Office of Continuing Medical Education, St. Louis, MO. For more information, call Cathy Caruso at (800) 325-9862.

November 6-8

4th Annual Infectious Disease Review. Crowne Plaza Hotel, Rockville, MD. Sponsored by the Clinical Center of the National Institutes of Health. CME Category I credits available. For more information, call Svetlana Lisanti at 1-800-231-0389.

November 8-12

96th Annual Meeting of the American Academy of Ophthalmology. Dallas Convention Center, TX. For more information, call (415) 561-8500.

November 12-15

Southern Medical Association's 86th Annual Scientific Assembly. Registration information will be forthcoming. For more information, call 1-800-423-4992.

November 12-15

Emerging Issues in Primary Healthcare. Grand Cypress Resort, Orlando, FL. Sponsored by the University of South Florida College of Medicine in cooperation with the Medical Education Network, Inc. Fees: $595, physicians; $495, nurses and others. For more information, contact Tim Clarke at 1-800-832-0779.

November 19

Practice Review and Update of Infectious Disease. Allis Plaza Hotel, Kansas City, MO. Sponsored by the Department of Internal Medicine, Division of Infectious Disease, University of Kansas Medical Center. AMA Category I, American Academy of Family Physicians, and American Nurses Association credit hours available. For more information, call Mary Boyd at (913) 588-4488.

November 20-21

Hyperlipidemia. Sponsored by and held at the University of California, Davis, Medical Center, Office of Continuing Medical Education, Sacramento, CA. CME Category I credits available. For more information, call (916) 734-5390.

November 21

Hyperlipidemia. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine, Office of Continuing Medical Education, St. Louis, MO. For more information, call Cathy Caruso at (800) 325-9862.

"Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin, Member, American Medical Association

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While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

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You are invited to join Dr. Fullin and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

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Keeping Up

Advanced Cardiac Life Support ACLS

October 22, 23, 8:00 a.m., Russellville. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $150.00. For more information, contact Cindy Reid at (501) 686-5261.

Advanced Cardiac Life Support (ACLS)

October 29, 30 and November 5, 6, 8:00 a.m., Camden. Sponsored by the UAMS College of Medicine. CME Category I credit available. Fees: $150.00. For more information, contact Cindy Reid at (501) 686-5261.

Primary Care Update

October 30, 8:00 a.m., J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Sponsored by Baptist Medical Center Medical Affairs, Little Rock. CME Category I credit available. Fees: $90.00, physicians; $40.00, others.

Arkansas Medical Society Fall Meeting

November 22, Holiday Inn Airport, Little Rock. Registration information and meeting times will be forthcoming. For more information, call Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER
CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER
Medical Grand Rounds, Thursdays, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL
Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER
Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 11:30 a.m., Shuffield Auditorium
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Category 1 credits available. Lunch provided

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room

Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.

Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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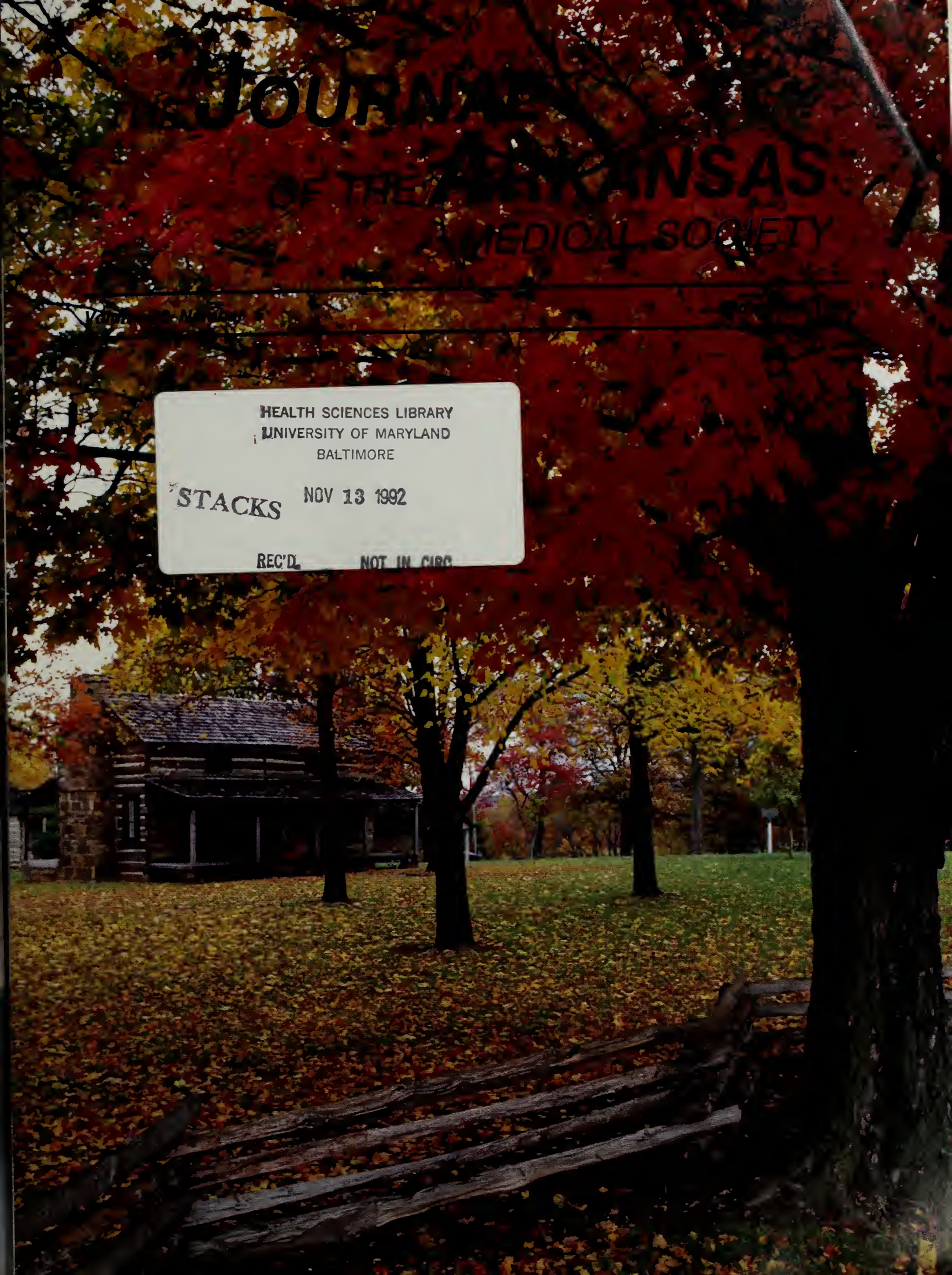

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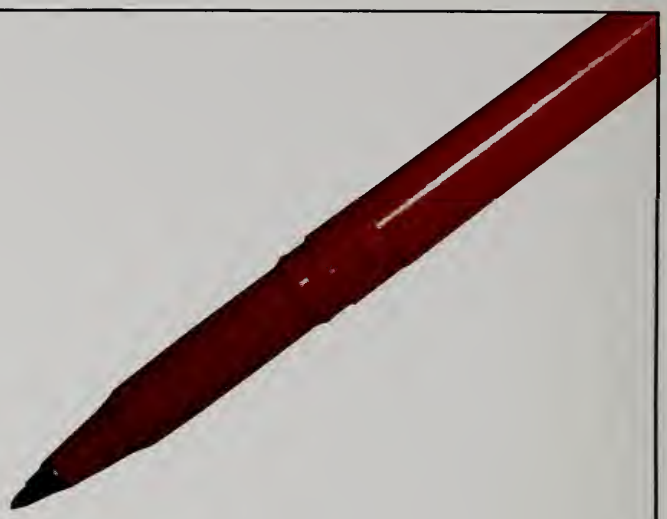

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Government and Other Regulations of Clinical Practice

Thomas L. Eans, M.D., F.A.A.F.P.*

All physicians are aware they are now in a heavily regulated profession, but there has been such an avalanche of new laws recently that most physicians probably are dismayed and have not been able to keep current with them. There are onerous burdens placed on our profession today that many may not be able to bear. Knowledge of these may affect a choice of specialty or practice mode or may result in a student choosing to avoid this profession altogether. This article is intended to be educational for both current and future physicians. This a partial compilation. It also is not meant to be an adequate explanation of any one item. It is written for applicability to a small outpatient family practice clinic. Larger clinics or institutions may have additional requirements. Specialty clinics with no labs or x-ray and those not dealing with Medicare and Medicaid will have less requirements.

Table 1 lists the items required to be displayed on a wall of your clinic. Sources for these posters are shown in parentheses. You must post the State Minimum Wage Notice if you have four or more employees and less than $500,000 gross income and no interstate commerce. Otherwise you must post the Federal Minimum Wage Notice. You may post both. The Equal Opportunity poster describes the Civil Rights Act, the Age Discrimination Act, and the Americans with Disability Act.

* Dr. Eans is a family physician associated with the Southwest Family Clinic in Little Rock.

Other items that must be available to you, your employees or inspectors of your business include the following:

- Business sign permits
- Fire department inspection reports
- Payroll records and workers compensation or unemployment claims
- Pension plans and insurance benefits records and filings
- W4's and W9's, Federal and State unemployment tax returns and all other business financial records
- Federal tax ID number
- State medical license
- Drug enforcement administrator (BNDD) certificate
- Controlled drug inventory records and Schedule II order forms
- Federal motor carrier safety regulations (If you perform Department of Transportation exams or drug screens)
- Agreements and contracts with Medicare (various), Medicaid, Medicaid EPSDT, private insurances, HMO's and PPO's
- Medicare and Medicaid clinic and/or personal provider numbers
- Medicare unique provider identification numbers for yourself and any referring physicians
- Lab CLIA certification number
- Special Medicare limiting charge list (If you are not Medicare participating)

- Medicare and coinsurance extended payments requests
- Medicaid CoPay financial accounting
- Medicaid provider tax financial accounting and returns
- Chemical hazard law and exposure control plan and associated documentation
- Bloodborne pathogens hazard law and exposure control plan and associated documentation
- X-ray administrative and technical procedures manual and associated documentation; eg, X-ray dosimetry reports
- Laboratory procedures manual and CLIA 88 law and associated documentation, including your CLIA certificate

Other necessary but not necessarily legally required documents include the following:

- Employment policies and periodic personnel reviews
- Malpractice insurance policy
- Unemployment, worker's compensation, liability, contents, and building insurance policies
- Utility and rent deposit records
- Rental contracts, maintenance contracts, and termite contracts
- Medicare, Medicaid, HMO and PPO policy manuals
- Diagnoses coding book
- Service/Procedure coding books

You must also have knowledge of the proper prescribing of controlled drugs as determined by the FDA, DEA and State Medical Board. You may also need to know the laws regulating dispensing of drugs in your facility. You must have knowledge of federal and state laws on the care of the terminally ill and demented. You must be aware of the requirements on new or remodeling construction for the special needs of the handicapped public or your employees.

You must maintain adequate clinical records to prove to a reviewer using his criteria that you delivered the quantity and quality of medical care for which you billed. You may also be required to use your records to prove to a judge and jury that you were absolutely perfect in your appointment scheduling, testing, diagnoses, treatments and referrals; you then hope that perfection will be considered satisfactory.

You and your staff must have the ability to foresee Medicare and Medicaid policies regarding medical care and billing when these agencies aren't reasonable or intelligent enough to explain the policies until after their effective date.

For the above, your liability ranges from a warning to extremely harsh penalties from various government agencies for noncompliance, including possible federal prison sentences, even if your acts are innocent oversights. You may be presumed guilty until proven innocent and you usually don't have the right to a jury trial.

Table 1. Posters to Display in the Office

Employee Polygraph Protection Act (Dept. of Labor)
Minimum Wage and Overtime Act (Dept. of Labor)
Job Safety and Health Protection Act (Dept. of Labor)
Employment Opportunity Acts (Equal Employment Opportunity Dept.)
Workers' Compensation Injuries and Illnesses Notice (Insurance Carrier)
Business License (City)
X-ray Registration Certificate (Ark. Dept. of Health)
Employee Radiation Protection Notice (Form RH2400 from your Arkansas Board of Health Radiation Regulations Manual)
Chemical Material Safety Data Sheets Location Notice (You make it)

Although the above may seem tyrannical or at least grossly excessive abuse of power, there is absolutely no reason to think the government regulatory monsters are satisfied. Future regulations may encompass forced computer use for billing or clinical purposes, use of metric system of measurement, use of international units for laboratory measurements, and more special educational requirements for physicians or employees. There may also be conscription of physicians for compulsory service in rural or depressed urban areas, compulsory Medicare assignment and Medicaid participation or universal health care and charge limitation with outlawing of private care availability with the possible exception of that for the privileged regulation makers themselves.

The most problematic laws and agencies are federal and thus may be controlled by aloof individuals who are unresponsive to grass roots input and may even have a malicious attitude toward the medical profession in particular. This is in contrast to local or state entities whose ears are often promptly available to your telephone call, especially in Arkansas. It should be pointed out though that the local offices of some federal agencies can be quite helpful and responsive in answering inquiries about their regulations. It is essential today that every physician keep abreast of the plethora of regulations on his practice. Expert assistance is not adequate. Personal attention to the details is necessary and often dictated by these laws. ■

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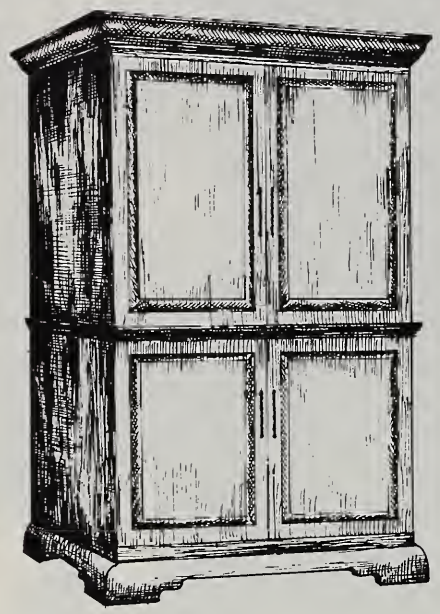

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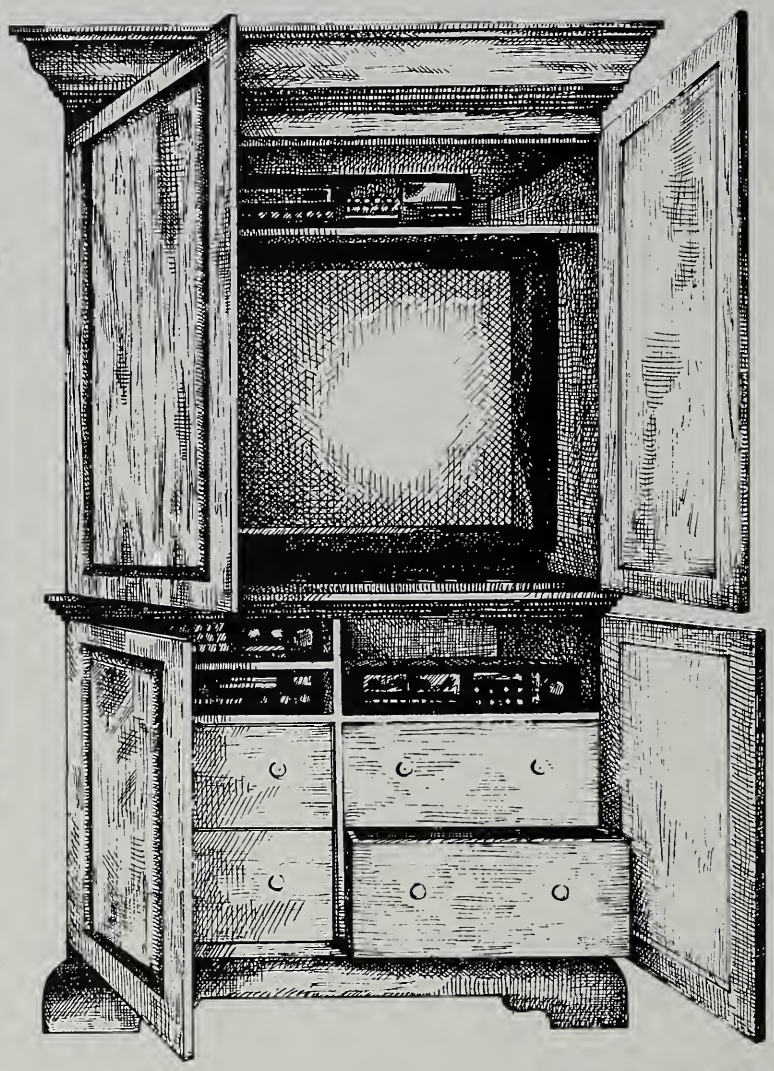

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Effects of Serum Acid Phosphate Elevation Following Transurethral Prostatectomy on Long-Term Mortality

Pat D. O'Donnell, M.D.*
Shawn C. Lancaster, B.S.**

Studies of surgery for symptoms of bladder outlet obstruction in men suggest that a possible higher long-term mortality occurs in patients having transurethral prostatectomy compared with patients having an open prostatectomy. It is the purpose of this study to determine if intraoperative factors affect the long-term survival of patients having transurethral prostate resection for benign prostate hypertrophy. In 158 consecutive patients having transurethral prostatectomy for benign adenoma who were followed for eight years, 28 patients died during the follow-up period. In comparing those patients who are alive with those patients who have died, there was no significant difference at the time of surgery in intraoperative irrigant absorption as indicated by changes in serum sodium and there was no significant difference in the intraoperative absorption of prostate tissue substances as indicated by changes in serum acid phosphatase. The only factor in this study associated with long-term survival was age of the patient at the time of surgery with older patients having a higher long-term mortality. This study suggests that age of the patient rather than intraoperative factors is associated with long-term survival following transurethral prostatectomy.

* Dr. O'Donnell is a professor in the Department of Urology at the University of Arkansas for Medical Sciences in Little Rock.

** Ms. Lancaster is a medical student with the College of Medicine at the University of Arkansas for Medical Sciences in Little Rock.

Transurethral prostate resection is the most common surgical intervention used for management of bladder outlet obstruction in older men. Studies related to the long-term mortality following surgery suggest the possibility that a higher long-term mortality occurs following transurethral prostate resection compared with patients having an open prostatectomy.[1,2] The observed differences in long-term survival do not appear to be accounted for by comorbid factors or age of the patient. It is possible that unmeasured patient characteristics contribute to the long-term mortality that has been observed. Another possibility is that there are intraoperative events that occur during a transurethral prostatectomy which contribute to differences in long-term survival. The intraoperative events that are clinically observed include absorption of irrigant solution, blood loss, and absorption of prostate tissue substances.

Since the early experiences of surgeons performing transurethral prostate resections, the adverse effects of intraoperative absorption of irrigant solution have been described.[2-8] Postoperative fibrinolysis was noted by urologists during the early years of transurethral prostate resections[9,10] and hemorrhagic syndromes following transurethral prostate resections due to disseminated intravascular coagulation have been described.[11]

During transurethral prostate resections, the prostate tissue substances are released into the irrigant

solution as evidenced by elevation of acid phosphate in the irrigant solution.[12] The intraoperative absorption of irrigant solution is associated with absorption of the prostate tissue substances contained in the irrigant solution. Serum acid phosphatase elevation following transurethral resection for benign adenoma occurs in more than three-fourth (77%) of patients operated.[13] More than one-third (37%) have been shown to have an elevation of serum acid phosphatase to a level higher than five International Units per liter (IU/L). The transient elevation of serum acid phosphatase following transurethral prostate resection has been associated with post transurethral resection syndromes.[14,15] Animal studies have demonstrated a dilutional effect following glycine infusion[16] and coagulation abnormalities have been associated with infusion of prostate tissue substances.[17] While the acid phosphatase concentration varies with different tissue specimens, the serum acid phosphatase level is indicative of the amount of prostate tissue substances infused in animals.

The long-term effects of the intraoperative events in patients having transurethral prostatectomy are unclear. It is the objective of this study to determine the effects on long-term mortality of intraoperative absorption of prostate tissue substances as evidenced by changes in serum acid phosphatase levels during transurethral prostatectomy. Also, any effects of intraoperative absorption of irrigant solution on long-term mortality are elevated by measuring intraoperative changes in serum sodium.

Methods

The eight-year morality was determined in 158 consecutive patients undergoing transurethral prostate resection for benign adenoma during 1983. Preoperative and postoperative electrolytes and acid phosphatase were determined prospectively in all patients operated. Preoperative urine culture was negative in all patients studies. Preoperative serum acid phosphatase was within normal range in all patients (< 0.8 IU/L). All patients had transurethral prostate resection using spinal anesthesia. An intermittent flow of glycine irrigant was used in all patients studied. When the operative procedure was performed, a blood sample was drawn at the end of the operative procedure in each patient by the anesthesiologist for measurement of serum acid phosphatase and serum sodium.

The eight-year survival status of the patient was determined by review of the medical record, telephone communication, personal correspondence, and follow-up clinical evaluation. In many of the patients who have died during the follow-up period, death occurred outside the hospital. In rural areas, the cause of death in these cases is occasionally attributed to a "heart attack" since there may be no actual evidence available for the cause of death. For this reason, the cause of death data are not included in the outcome of this study. In the data analysis, the intraoperative changes were compared for the group of patients that are alive with those who have died. A comparison of the mean values for each group was done using a standard T-test.

Results

Of the 158 patients operated, 28 patients died during the eight-year follow-up. The mean age of all patients operated was 68.3 (SD=7.3) years old. The mean age of those patients surviving was 67.3 (SD=7.3) years old while those who have died was 72.6 (SD=5.5) years old. The patients who died during the follow up interval were significantly older at the time of surgery than those who have survived (P<.01).

The preoperative serum acid phosphatase was normal in all patients operated (<0.8 IU/L) and the pathological specimen was histologically benign. The postoperative serum acid phosphatase for all patients operated was 7.6 (SD=9.5) IU/L (range=0.18 IU/L - 50.2 IU/L). The mean postoperative serum acid phosphatase in those patients who have survived was 7.5 (SD/9.9) IU/L while the mean postoperative serum acid phosphatase in those who have died was 7.7 (SD=7.6) IU/L. Since the preoperative serum acid phosphatase was less than 0.8 IU/L in all patients, the actual postoperative value also represents the intraoperative change. There is no significant difference in the postoperative serum acid phosphatase in the patients who have survived and those who have died (p=.91).

The preoperative serum sodium in all patients operated was 139.8 (SD=3.2) milliequivalents per liter (meq/L) while the mean serum sodium following surgery was 135.2 (SD=6.2) meq/L. The mean serum sodium before surgery in those patients who have survived was 139.9 (SD=3.1) meq/L, while the serum sodium before surgery in those who have died was 139.1 (SD=3.3) meq/L (no significant difference, p=.25). The serum sodium following surgery in the group who survived was 135.3 (SD=6.2) meq/L while those who have died was 135.1 (SD=6.7) meq/L, (no significant difference). The mean change in serum sodium during surgery for all patients operated showed a decline in serum sodium by 4.5 (SD=6.1) meq/L. The mean change in serum sodium during surgery for those who survived was 4.6 (SD=6.1) meq/L while those who have died was 4.0 (SD=6.2) meq/L, (no significant difference, p=.64).

Discussion

As has been previously indicated, the issue of long-term survival related to transurethral prostate resection will require a study specifically designed to achieve that objective. The preliminary descriptive studies have not been able to account for the differences in survival by either age or comorbid factors. If these observations are

supported by further studies, then the question of difference in long-term survival between transurethral prostatectomy and open prostatectomy will require further investigation to determine whether the difference is related in any way to an intraoperative event. Events that commonly occur intraoperatively during transurethral prostate resection are absorption of irrigant solution, intraoperative bleeding, and absorption of prostate tissue substances. The long-term effects of intraoperative absorption of glycine solution are unknown, but are unlikely to result in long-term increase in mortality. Intraoperative blood loss is common in surgical procedures and is unlikely to be a factor that accounts for differences in long-term survival between transurethral prostate resection and open prostatectomy.

The extent of intraoperative absorption of prostate tissue substances during open prostatectomy is unknown, although it is likely to be less than that of a transurethral prostate resection. The long-term effects of the intraoperative absorption of prostate tissue substances during transurethral prostate resection are unknown. This study suggests that based on serum acid phosphatase as an indicator of the intraoperative absorption of prostate tissue substances, there are no long-term effects of the intraoperative absorption of these substances related to survival. In addition, if there are other substances absorbed intraoperatively that are not associated with the measured level of acid phosphatase following surgery, the level of intraoperative absorption of these substances would most likely be related to irrigant absorption as indicated by changes in serum sodium, which also are not associated with differences in survival in this study.

In this study, there is no difference in patients who are alive and those who have died at eight years following transurethral prostate resection in the intraoperative absorption of prostate tissue substances as indicated by the intraoperative changes in serum acid phosphatase as well as intraoperative absorption of irrigant solution as indicated by change in intraoperative serum sodium. The only factor in this study associated with long-term survival was age of the patient at the time of surgery with the older patients having a significantly higher long-term mortality.

References

1. Malenka DJ, Roos N, Fisher ES, et al. Further study of the increased mortality following transurethral prostatectomy: a chart-based analysis. J Urol. 1990;144:224-228.

2. Roos NP, Wennberg JE, Malenka DJ, et al. Mortality and reoperation after open and transurethral resection of the prostate for benign prostatic hyperplasia. N Engl J Med. 1989;320:(17)1120-1124.

3. Emmett JL, Gilbaugh JH, McLean P. Fluid absorption during transurethral resection: comparison of mortality and morbidity after irrigation with water and non-hemolytic solutions. J Urol. 1969;101:884-889.

4. Mebust WK, Brady TW, Valk WL. Observations on cardiac output, blood volume, central venous pressure, fluid and electrolyte changes in patients undergoing transurethral prostatectomy. J Urol. 1970;103:632-636.

5. Ceccarelli FE, Mantell LK. Studies on fluid and electrolyte alterations during transurethral prostatectomy: I. J Urol. 1961;85:(1)75-82.

6. Harrison RH, Boren JS, Robison JR. Dilutional Hyponatremic Shock: another concept of the transurethral prostatic resection reaction. J Urol. 1956;75:(1)95-110.

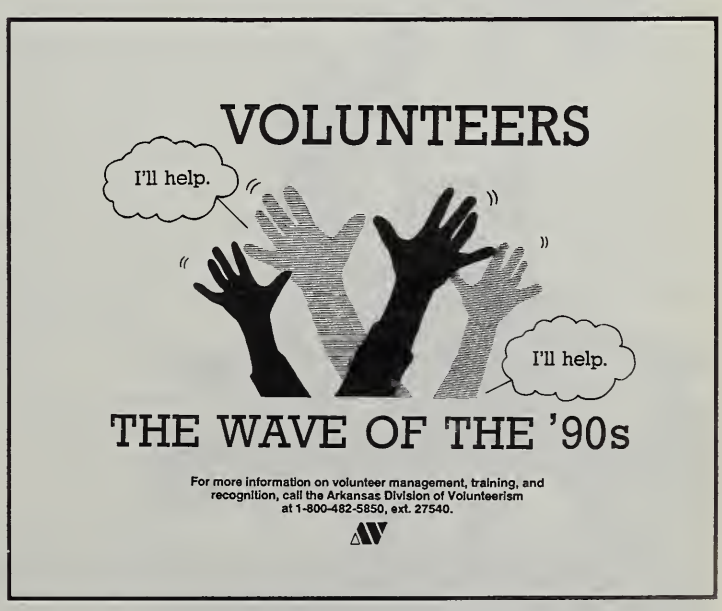
7. O'Donnell PD, Fody EP, McHan S. Effects of transurethral prostatectomy on nonelectrolyte components of serum. Urology. 1986;28:(1)45-47.

8. Madsen PO, Knuth OF, Wagenknecht LV, Genster HG. Induction of diuresis following transurethral resection of prostate. J Urol. 1970;104:735-738.

9. Entz FH. Fibrinolysis: a complication of transurethral resection of the prostate gland. J Urol. 1964;91:(6)671-675.

10. Lombardo LJ. Fibrinolysis following prostatic surgery. J Urol. 1957;77:(2)289-296.

Additional references available upon request. ■



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AIR FORCE

Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish

Miles J. Edwards, M.D.*
Susan W. Tolle, M.D.*

Recently we assisted in withdrawing life support from a patient who had repeatedly asked to have his ventilator disconnected, even after being informed that he would then die. We found little in the medical literature to guide us, especially at the feeling level, so we are sharing our experience with the hope that others will find our emotional responses, reasoning, and procedures useful.

The Case

Mr. Larson was a 67-year-old, obese white man. At 23 years of age he developed poliomyelitis and "spent six weeks in an iron lung." His neurologic recovery was virtually complete, and he resumed a reasonably normal life.

In November 1990, he noted the onset of rapidly progressive dyspnea and weakness in his extremities. A month later, he was hospitalized. He was endotracheally intubated and then underwent a tracheostomy to provide continuous mechanical ventilation. Numerous attempts to wean the patient from the ventilator always failed within one to two minutes. He was alert and frustrated by his ventilator dependence and demonstrated some symptoms of situational depression. After careful pulmonologic and neurologic evaluation, his condition was attributed to "post-polio syndrome."

When the patient asked if he would ever be able to live without the ventilator, pulmonary and neurology consultants told him that he would always be ventilator dependent. One consultant felt that he might improve enough to be taken off the ventilator during the day but that he would probably continue to need it at night. All consultants concurred that he would never become totally ventilator independent. The patient listened and, after thinking it over, asked to have ventilatory support discontinued. He stated that he realized he would die without such support.

A psychiatrist evaluated the patient and agreed that he was somewhat depressed, although not severely enough to affect his decision-making capacity. After some initial reservations, the patient's family (one grown daughter and two grown sons) showed strong support for his decision. The patient consistently made it clear that living on continuous mechanical ventilation, with the consequent inability to speak, rendered the quality of his life unacceptable. He continued to express his wish to discontinue ventilation over a 2-week period and asked to be heavily sedated in the process. Because of his unwavering request, we were called in as ethics consultants.

Ensuring that Ventilator Withdrawal is Right for the Patient

We believe that after careful consideration in selected cases, withdrawal of the ventilator from an awake patient, allowing a natural death to occur, is the right thing to do. We object to the term "passive euthanasia";

* Drs. Edwards and Tolle are with the Center for Ethics in Health Care at the Oregon Health Sciences University in Portland.

it is not killing the patient. It is instead stepping aside and allowing the disease to take its natural course when that course is the consistent choice of a competent patient. The question then is whether that choice is ethically supportable in a particular patient. What do we need to consider before making this decision? And if we do decide to disconnect the ventilator, how can that be done with compassion to minimize or eliminate the patient's suffering?

We accept the ethical and legal principles that patients have the right to refuse medical treatment, even when they may die as a result. However, we have an obligation to verify that the refusal of life-sustaining treatment is the durable request of a mentally competent, well-informed patient. In Mr. Larson's case, we needed more information before we could respond to his request. We identify seven actions that must be addressed before such a request should be acted on:

❶ Clarify the prognosis.
❷ Be assured of the patient's decision-making capacity (and of the absence of a medically significant depression that might temporarily affect his or her judgement).
❸ Assure durability of the patient's wish.
❹ Identify any coercive influences, either personal or financial.
❺ Explore concurrence of all family members.
❻ Explore concurrence of all members of the health care team.
❼ Consider legal mandates.

During the one week of our consultation, we talked repeatedly to the patient, separately to all three children, and also to some close friends of the family. One son appeared to have some misgivings, but they really represented, as further inquiry revealed, his great unhappiness about his father's condition. After coming to terms with those feelings, he agreed with his father's decision. We continued to explore the attitudes of all family members. From an ethical perspective, the patient's wishes should be respected, and unanimous agreement from the family is not necessarily required. However, we did obtain unanimous agreement from the family in support of our patient's decision.

We concluded that for Mr. Larson, withdrawal of the ventilator was both legally and ethically supportable, recognizing the right of competent, informed adults to refuse medical treatment. Then came the particularly difficult question: How could this be done with compassion and with a minimum of suffering?

Discontinuing Mechanical Ventilation in a Conscious Patient

The Patient's Right to Sedation

Discontinuing mechanical ventilation is a uniquely difficult process for the patient, the family, the physician, and other members of the health care team. Regardless of how strongly the patient may wish to have this done, the sudden feeling of suffocation that results leads to a visceral panic. This sensation constitutes the greatest of suffering. Therefore, we believe that it is mandatory to provide sedation to awake patients before ventilation is withdrawn. Any use of sedative or narcotic analgesic medication to relieve the unwanted sensations would also reduce respiratory drive; the two are inseparable. It is a physiologic reality, then, that sedating the patient probably accelerates death by some small measure of time. However, it had been determined through multiple previous attempts to wean this patient from the ventilator that death would occur anyway, so sedating the patient would not in itself cause the death.

In Mr. Larson's case, we did not advise on the types or doses of sedatives, but we did encourage adequate sedation. We suggested that the attending physician consult with an experienced pulmonologist-intensivist on the details of ventilator withdrawal, including dosing of sedation. We acknowledge that titrating sedation is difficult when the goal is relief of suffering without deliberately inducing a respiratory arrest. Marked variability in both individual needs and drug tolerance further complicates these estimates. Ideally, the patient will be heavily sedated but will continue to maintain his or her respiratory efforts.

Our Planning

We submitted our ethics consultation report to the team and were informed by the intern that the disconnection was to be done three days later, on February 25, 1991 at 10:00 a.m. We suggest selecting a particular time for several reasons: it allows further time to assure durability of the patient's request, and it allows the patient and family to say final good-byes, decide who will be present, arrange last rites, and so forth; in addition, selecting a time early in the day ensures that the physician and primary nurses are available in case the patient does not die right away and needs further comfort and support. A disadvantage of setting a specific time is that any delay will be a further stress for the patient and family.

Final details were planned with the patient and the health care team. The patient requested that several members of his family be present (they wanted to be there), while others would wait in an adjoining room. The primary care team discussed who would do the disconnection and decided that the pulmonary consultant and attending staff physician would administer sedatives and disconnect the ventilator. We saw our role as ethics consultants finished.

The Disconnection

Loving family had been present throughout Mr. Larson's stay, and their numbers increased as the time of disconnection approached. By 9:00 a.m., February 25, 13 family members and close friends were at the patient's bedside awaiting the disconnection. All anticipated that this would lead to the patient's death. We were not in attendance. At 9:30 a.m., we received a call from a distraught intern telling us that the family was there and all were ready. However, both the pulmonologist and the attending physician would not be available until five hours later, at 3:00 p.m. The intern felt that she alone would have to disconnect the ventilator, something she was not technically or emotionally prepared to do and had never done before. The primary care team had not verified the pulmonary consultant's availability when the disconnection was planned. The attending physician had been called away unexpectedly and had delegated this job to the intern. We believe very strongly that this would not be an appropriate procedure for the anxious intern to do alone. Although we were both technically qualified as pulmonologist-intensivist and internist to perform the disconnection, we felt that being involved this way was beyond our role as ethics consultants. (We believe that an experienced pulmonologist-intensivist should always be involved.) Nevertheless, the patient had already waited a week while we had undertaken the seven actions outlined earlier, and we felt it would be cruel for him and his family to wait any longer. So with much trepidation, we decided that we would provide sedation and disconnect the ventilator ourselves. After this experience, we conclude that the attending physician *should* be the main player, with a pulmonologist-intensivist in attendance to provide necessary technical expertise. This is not a job for interns or inexperienced physicians.

We talked with the patient again to see if he still wanted this to be done and informed him that we would be performing the disconnection. He said "yes" emphatically. The family and other members of the health care team agreed. We told the patient we could not know exactly what dose of medication would be ideal and that we might err in either direction. We explained that if we judge low in our estimate, he would suffer from dyspnea. We asked his permission to reconnect the ventilator briefly if that happened, so that we could calmly administer additional medication. We would then disconnect again. He hesitated, but agreed. We again reminded him and the family that he might not die immediately. We told them that although we did not expect it, there was a slight chance he might continue to breathe for 24 hours or more. Our tests indicated he would not be able to breath on his own, but occasionally patients live longer than we expect. If such was the case, we planned to start an intravenous drip of morphine to ensure his comfort.

A venous line was placed. We looked into the face of an alert man who we know would soon die. Our more rational intellects told us that his disease, not us, would be the cause of his death. Deep feelings, on the other hand, were accusing us of causing death. From deep within us, feelings were speaking to us, making accusations, "You are really killing him, practicing active euthanasia, deceptively rationalizing with your intellects that there is a difference." These were not new feelings, but they were now greatly intensified as we stood there next to the patient, preparing to use syringes containing midazolam and morphine. Both are known respiratory depressants, which at high doses would be effective in active euthanasia and even at therapeutic doses would at least cause some respiratory depression and perhaps an earlier death. Nevertheless, midazolam and morphine were medically indicated to provide comfort to withdraw the ventilator in compliance with his request. We respected his right to refuse further life dependent on the ventilator. A heavy feeling of intense emotion consumed both of us as we slowly injected midazolam and morphine, watching the patient closely so we could produce the desired level of drowsiness. He reached what we thought was the correct end point, and one of us disconnected the tube to the ventilator while the other was poised at the catheter in case more medication was necessary. We stood frozen as Mr. Larson continued to take shallow but regular breaths. We felt some relief; at least we had not sedated the patient so heavily that this alone would cause his immediate death.

Within a minute or so, the patient turned slightly cyanotic and began to struggle. With trembling hands, we pushed more midazolam and morphine, reaching final total doses of 15 mg midazolam and 30 mg morphine sulfate. (These doses apply directly to this patient and are not recommended for anybody else; people differ greatly in their tolerances.) Mr. Larson seemed comfortable, breathing shallowly at a rate of 28/minute. He exchanged smiles with his daughter, who stood holding his hand across the bed. He appeared reasonably comfortable and relaxed. We both felt a great heaviness and deep sense of anxiety. To facilitate communication among the 13 friends and family, we requested further support by the patient advocate (who had also been involved throughout the earlier discussions). Several family members provided regular updates to family members in the adjoining room. His daughter, the primary nurse, the intern, and the two of us remained at his bedside. Mr. Larson did not struggle further. Forty-five minutes after the disconnection, his breathing became irregular and stopped. He was not attached to any monitors, which probably reduced the strain on the family during the final minutes. His heart continued to beat for several minutes, first regularly, then with pauses. We took turns listening and waited

until we were certain that he had died. Fifty-three minutes after he was disconnected from the ventilator, we pronounced him dead.

Although we received grateful hugs from the family and thanks from the health care team, we were struck by the gravity of what we had done. Doubts kept creeping into our minds. We each experienced a wave of disquieting emotion, feelings that we had killed this patient who would have otherwise continued to live connected to the ventilator. We knew intellectually that he had the legal and ethical right to refuse this medical treatment, but the gravity of his decision and our participation haunted us. We returned to our immediate commitments of caring for other patients, one of us responding next to the need of a patient who wanted medical help for a pulmonary problem to prolong his life. Both of us remained preoccupied throughout the afternoon thinking about Mr. Larson and what we had done. Our respective medical careers have generally been devoted to responding to patient wishes to postpone death and to prolong life. We've seen our patients die of their various diseases, but now our acquiescence in allowing his death caused us much anguish. This anguish continued in both of us for several days. One of us sought counsel from a psychiatrist who reinforced our belief that we did the right thing, counteracting those deep feelings that somehow we had killed this patient. Gradually we came to terms with what had happened. We had been in a complicated situation in which technology was sustaining life artificially, and we had acted on this patient's choice to refuse that treatment. Our consciences were clear, but we were left feeling very impressed with how difficult it had been to honor this man's request.

It is beyond the usual role of ethics consultants to take over patient care responsibilities and actually perform ventilator withdrawal. We do not intend to make it our practice to do this because it is really the appropriate role of the care-providers, who should enlist the help of a pulmonary-intensivist. We appreciate what we have learned from this unusual experience. After a period of reflection, we are no longer anxious about this decision, and we believe that we did the right thing in respecting Mr. Larson's request. Having witnessed from the bedside the suffering and the determination of this patient and his family, we feel better equipped to counsel other physicians whose patient care responsibilities will require them to grapple with similar end-of-life dilemmas.

Acknowledgement

The authors thank Bernard Lo, M.D., Michael Garland, D.Sc.Rel., Virginia Tilden, D.N.Sc., and Sandy Poole for their thoughtful reviews of this manuscript.

This article is reprinted with permission and originally appeared in the Annals of Internal Medicine, 1992;117:254-256. The patient's name was changed to protect patient confidentiality, and the family granted permission to share his story. ■

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The Senior Physicians of Arkansas: A Decade (Almost!) in Review

Fred Reddoch*

In April 1984, Pulaski County Medical Society Executive Secretary Paul Harris sent a brief memorandum to "senior" members of the Society seeking their input on the idea of forming an organization of senior doctors for the purpose of "maintaining contact with their colleagues and with the interests of organized medicine." The response to the memorandum was positive and an organizational meeting, attended by 22 physicians, was held on April 25, 1984. Three important decisions were reached at this meeting. First, the group decided to open up membership to any doctor age 65 or older, whether retired or not. Second, the group chose a name - The Senior Physicians of Arkansas. Third, John McCollough Smith was elected to serve as the first president. The S.P.A. flourished under Dr. Smith's charismatic leadership. After a few months, the group settled into a pattern of meeting on the second Wednesday of each month at St. Vincent Infirmary Medical Center for a program and a meal. When Dr. Smith died suddenly in May 1987, the members felt such loss that they renamed the organization the "John McCollough Smith Chapter of the Senior Physicians of Arkansas." Since Dr. Smith's death, three presidents have carried on his legacy of strong and devoted leadership: M.D. McClain (June 1987-1988), John Greutter (1989-January 1991), and Gilbert Dean (February 1991-present). Looking back through the minutes of the S.P.A., two things are particularly striking. The first is the consistency of the organization. In eight and a half years of existence, only two meetings have been missed - both due to bad weather. The second is the wide variety of programs featured at the meetings. They have ranged from magic shows to poetry readings, from medical topics to political commentary. Distinguished speakers have included: Governor Orval Faubus, John Robert Starr, Judge Elsijane Roy, Dr. Joycelyn Elders, and former First Lady Anne McMath. Good food, good friends, and good programs pretty much sum up the Senior Physicians of Arkansas. Who would have thought that one small memorandum would grow into an organization almost a decade old and still going strong? Dr. Dean invites all "senior" physicians, living anywhere in the central Arkansas area, retired or not, to participate in the Senior Physicians organization. Noon meetings are held on the second Wednesday of each month at St. Vincent. Please call the Pulaski County Medical Society office at 664-3402 if you would like more information. ■

* Mr. Reddoch is the executive director of the Pulaski County Medical Society in Little Rock, Arkansas.

Arkansas HIV/AIDS Report 1983-1992

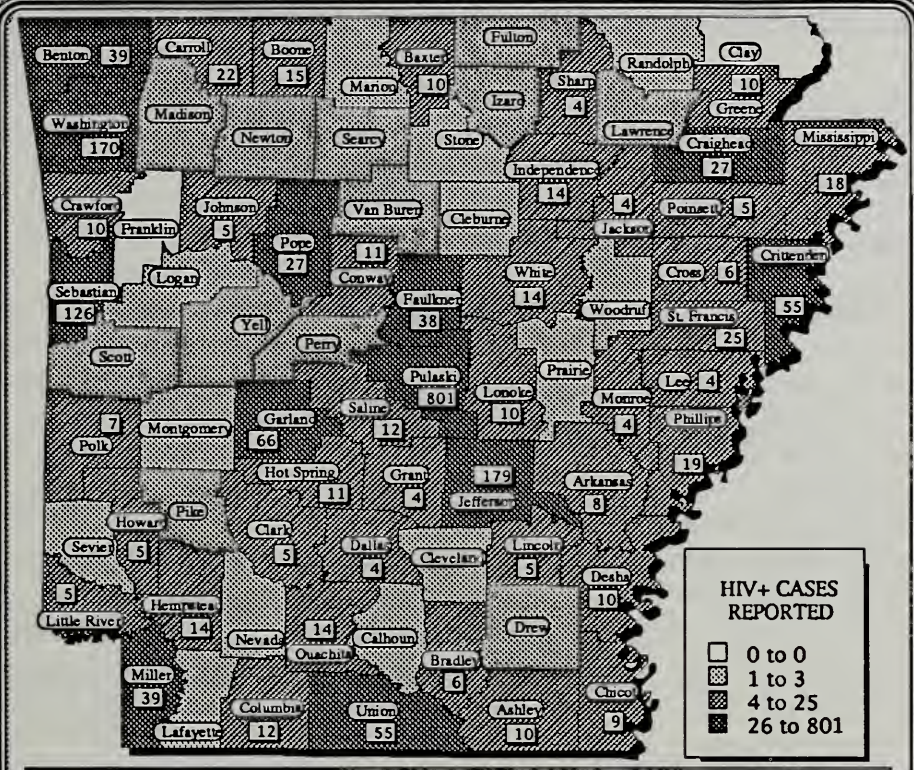
Arkansas: June 1983 through September 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	213	251	437	421	306	1,731	85.44
	Female	1	1	6	27	39	72	89	60	295	14.56
AGE	< 5	0	0	1	1	2	9	14	4	31	1.53
	5-12	0	0	0	1	1	5	2	0	9	0.44
	13-19	0	0	0	8	8	14	20	22	72	3.55
	20-29	8	10	15	109	125	192	154	125	738	36.43
	30-39	7	15	22	86	105	206	219	140	800	39.49
	40-49	4	7	11	24	35	62	73	48	264	13.03
	> 49	1	1	6	6	12	19	23	25	93	4.59
	Unknown	0	0	0	8	2	2	5	2	19	0.94
RACE	White	16	24	47	171	178	353	312	224	1,325	65.40
	Black	4	9	8	70	107	153	195	135	681	33.61
	Other	0	0	0	2	5	3	3	7	20	0.99
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	366	2,026	100%

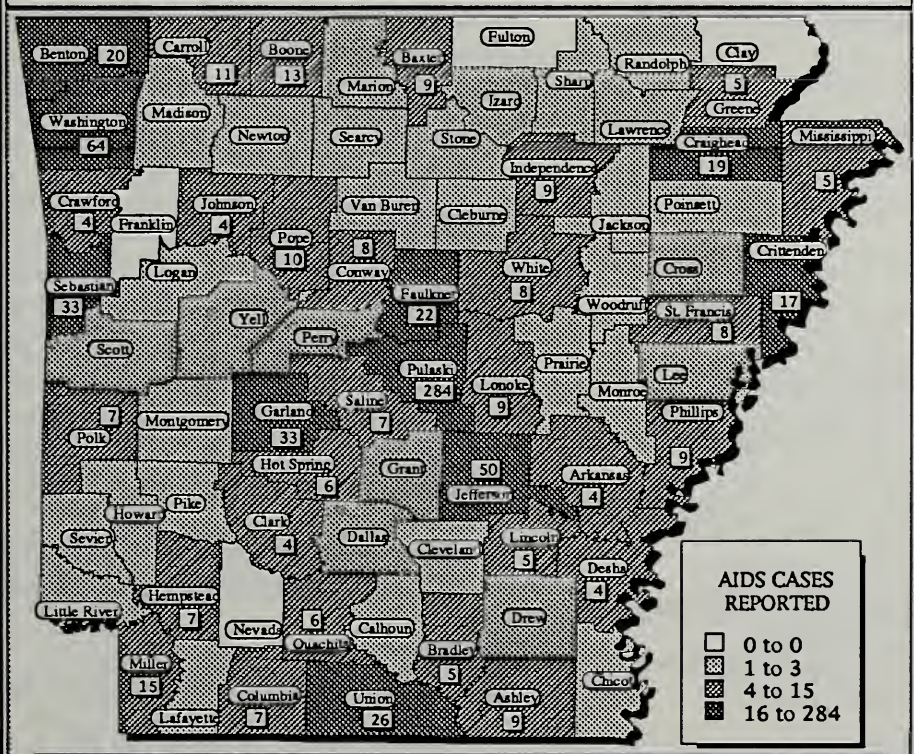
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	169	747	89.35
	Female	1	0	4	6	10	20	25	23	89	10.65
AGE	< 5	0	0	0	1	1	6	6	1	15	1.79
	5-12	0	0	0	1	0	1	1	0	3	0.36
	13-19	0	0	0	0	0	4	3	1	8	0.96
	20-29	7	9	15	27	24	55	57	52	246	29.43
	30-39	3	13	23	36	41	78	80	84	358	42.82
	40-49	1	6	8	10	7	35	41	38	146	17.46
	> 49	1	0	4	8	7	11	13	16	60	7.18
RACE	White	9	22	43	61	58	141	134	135	603	72.13
	Black	3	6	7	20	21	47	66	55	225	26.91
	Other	0	0	0	2	1	2	1	2	8	0.96
RISK	Male/Male Sex	7	17	31	59	50	118	118	111	511	61.12
	Injection Drug User (IDU)	0	2	10	4	11	18	28	26	99	11.84
	Male/Male Sex & IDU	3	9	4	6	6	18	17	13	76	9.09
	Heterosexual	2	0	2	3	6	10	10	16	49	5.86
	Transfusion	0	0	2	7	3	7	11	3	33	3.95
	Perinatal	0	0	0	1	1	6	6	1	15	1.79
	Hemophiliac	0	0	0	1	1	5	5	2	14	1.67
	Undetermined	0	0	1	2	2	8	6	20	39	4.67
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	192	836	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



A total of 2,026 Arkansans have been reported to be HIV+ as of September 25, 1992.



A total of 836 Arkansans have been diagnosed with AIDS as of September 25, 1992.

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

BATESVILLE

Bowman, Gary W., Family Practice/Emergency Medicine. Born, 4/11/58. Medical education, Oklahoma State University College of Osteopathic Medicine, Tulsa, 1989. Internship/residency, Jefferson Regional Medical Center/AHEC, Pine Bluff, 1992. Board certified.

FAYETTEVILLE

Blankenship, James B., Neurosurgery. Born, 9/2/60. Medical education, UAMS, 1986. Internship/residency, UAMS, 1992. Board eligible.

Cameron, Mark A., Family Practice. Born, 3/5/52. Medical education, University of Oklahoma, Oklahoma City, 1979. Internship/residency, Oklahoma University Health Science Center, Bartlesville, 1982. Board certified.

Snyder, Norman I., Child, Adolescent & General Psychiatry. Born, 9/15/45. Medical education, Wayne State University School of Medicine, Detroit, MI, 1972. Residency, Lafayette Clinic & Wayne State University School of Medicine, 1976. Board eligible.

FORT SMITH

O'Bryan, Robert K., Anesthesiology. Born, 10/11/44. Medical education, Baylor College of Medicine, Houston, 1972. Internship/residency, US Naval Hospital, Oakland, CA, 1975. Board certified.

HAZEN

Boyd, Anita L., Family Practice. Born, 8/8/61. Medical education, UAMS, 1989. Internship/residency, UAMS, 1992.

HUNTSVILLE

DeValle, Oscar L., Family Practice. Born, 7/26/57. Medical education, Spartan Health Sciences University, St. Lucia, West Indies, 1987. Internship/residency, Fayetteville, 1992. Board certified.

JONESBORO

Hurst, William R., Family Practice. Born, 1/6/61. Medical education, University of Health Science College of Osteopathic Medicine, Kansas City, MO, 1988. Internship, Still Regional Medical Center, Jefferson City, MO, 1989. Residency, AHEC-NE, Jonesboro, 1992. Board certified.

LITTLE ROCK

Newbern, David G., Orthopaedic Surgery. Born, 11/18/59. Medical education, UAMS, 1986. Internship/residency, Georgetown University, Washington, D.C., 1992.

Schmitz, Susan B., Pediatrics. Born, 11/22/60. Medical education, University of Texas Medical School, San Antonio, 1987. Internship/residency, UCLA Medical Center-Harbor, Torrance, CA, 1990. Board certified.

Thompson, Joseph W., Pediatrics. Born, 6/13/62. Medical education, UAMS, 1985. Internship/residency, Arkansas Children's Hospital, 1992. Board certified.

MOUNTAIN HOME

Foster, Robert D., Orthopaedics & Spine. Born, 9/19/54. Medical education, Medical College of Georgia, Augusta, 1985. Internship/residency, Louisiana State University Medical Center, 1990. Fellowship, Ranchos Los Amigos Medical Center, Los Angeles, CA, 1991.

NORTH LITTLE ROCK

Evans, Clifford L., Radiation Oncology. Born, 6/28/39. Medical education, UAMS, 1964. Internship, St. Francis Hospital, Wichita, KS, 1965. Residency, University of Southern California, 1986. Board certified.

RUSSELLVILLE

Harden, Vernon A., Pathology. Born, 12/27/51. Medical education, UAMS, 1977. Residency, UAMS, 1981. Board certified.

SPRINGDALE

Landrum, Leslie G., Internal Medicine. Born, 4/12/57. Medical education, UAMS, 1989. Internship/residency, UAMS, 1992. Board certification pending.

Stagg, Stephen W., Internal Medicine & Gastroenterology. Born, 3/7/60. Medical education, LSU Medical School, New Orleans, 1985. Internship/residency, University of Texas Medical Branch, 1988. Board certified.

MEDICAL STUDENTS

Barrett, Rebecca L.
Boast, Amy L.
Boswell, Robert B.
Bradshaw, Amanda L.
Christoffersen, Brett A.
Eaton, Raye L.
Elkins, Anthony B.
Erwin, John S.
Gates, Janece K.
Hendrix, Lisa M.
Kennedy, James D.
Mehth, Sheena
Milligan, Lynda B.
Rankin, Jay K.
Rose, Steve
Runion, Lance K.
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Shirakbari, Alicia A.

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AMS Newsmakers

Dr. Henry Edwards, an internist from Van Buren, was named a board certified diplomat in geriatrics by the American Board of Internal Medicine.

Dr. J. Richard Gardial, a family practioner from Hot Springs, has been installed as president of the Arkansas Chapter, American Academy of Family Physicians.

Dr. Charles Jennings, an internist from Van Buren, was named a board certified diplomat in geriatrics by the American Board of Internal Medicine.

Dr. Aubry S. Joseph, a Pine Bluff radiologist, has been named as a fellow of the American College of Radiology.

Dr. Pat McCarty, a general practitioner from Helena, recently received the Arkansas Hospital Association's 1992 Distinguished Service Award.

Dr. Rick Ryals, a Jonesboro pathologist, has assumed the position of laboratory director for Doctor's Pathology Services, P.A., a Jonesboro clinical laboratory.

Dr. James Y. Suen, an otolaryngologist at the UAMS Medical Center and chairman of the Department of Otolaryngology in the College of Medicine at the University of Arkansas for Medical Sciences in Little Rock, was named as one of the 419 best cancer specialists in America, according to *Good Housekeeping* magazine.

Dr. Karen L. Young, a psychiatry resident from Conway, has been recognized by the American Medical Association for community service. She was one of 50 honorees for the AMA/Burroughs Wellcome Leadership Program for Resident Physicians.

AMA-ERF Scholarship Recipients

The Arkansas Medical Society Auxiliary recognized six medical students at the University of Arkansas College of medicine with the American Medical Association Education and Research Foundation Scholarships for 1992-93. The county chapters of the Auxiliary contribute each year to a scholarship fund for deserving medical students.

The AMA-ERF scholarship are awarded annually to medical students who demonstrate outstanding academic achievement and "possess the humanitarian skills to become caring and compassionate physicians." Through the fund-raising efforts of the county chapters, the Auxiliary has also funded many College of Medicine projects designed for teaching medical students. The number of scholarships awarded has increased over the years, from one in 1988 to six in 1992.

Presentation of the awards was made at the annual College of Medicine Scholarship Banquet. The Auxiliary was represented by Mrs. Jeannette Burgess and her husband, Dr. James Burgess of Russellville. Mrs. Burgess is the AMA-ERF Scholarship Chairperson for 1992-93. The recipients for 1992-93 are: **Matthew Smith**, freshman, Blytheville; **Reggie Vaden**, senior, Alexander; **Sherlita Reeves**, freshman, Paragould; **John Lazenby**, junior, Little Rock; **Sher Luningham**, senior, Little Rock; and **Charles Halter**, junior, North Little Rock.

Ilse F. Oates Scholarship Recipients

The University of Arkansas College of Medicine announced the 1992-93 recipients of the Ilse F. Oates Scholarships: **Chris Girkin**, Fort Smith; **Shelly Baldwin**, Magnolia; and **Jeff Bradley**, Rogers. The presentation was made by Mrs. Evelyn Thomas of Little Rock, Arkansas Medical Society Auxiliary Ilse F. Oates Scholarship chairperson for 1992-93, at the Annual College of Medicine Scholarship Banquet.

The Oates Scholarship is awarded to senior medical students who have exhibited "good clinical capabilities, good academic standing, and good moral character." Funds for the scholarship program are provided by the county chapters of the Arkansas Medical Society Auxiliary.

Mrs. Ilse F. Oates, who was married to Dr. Charles Oates, a professor at the School of Medicine, "adopted" medical students and provided them with spending money and small loans in 1919, long before there were any student financial aid programs. In 1928, she organized a loan program through the Auxiliary. In 1990, the Auxiliary converted the loan program to a scholarship program to recognize senior medical students who demonstrate outstanding potential.

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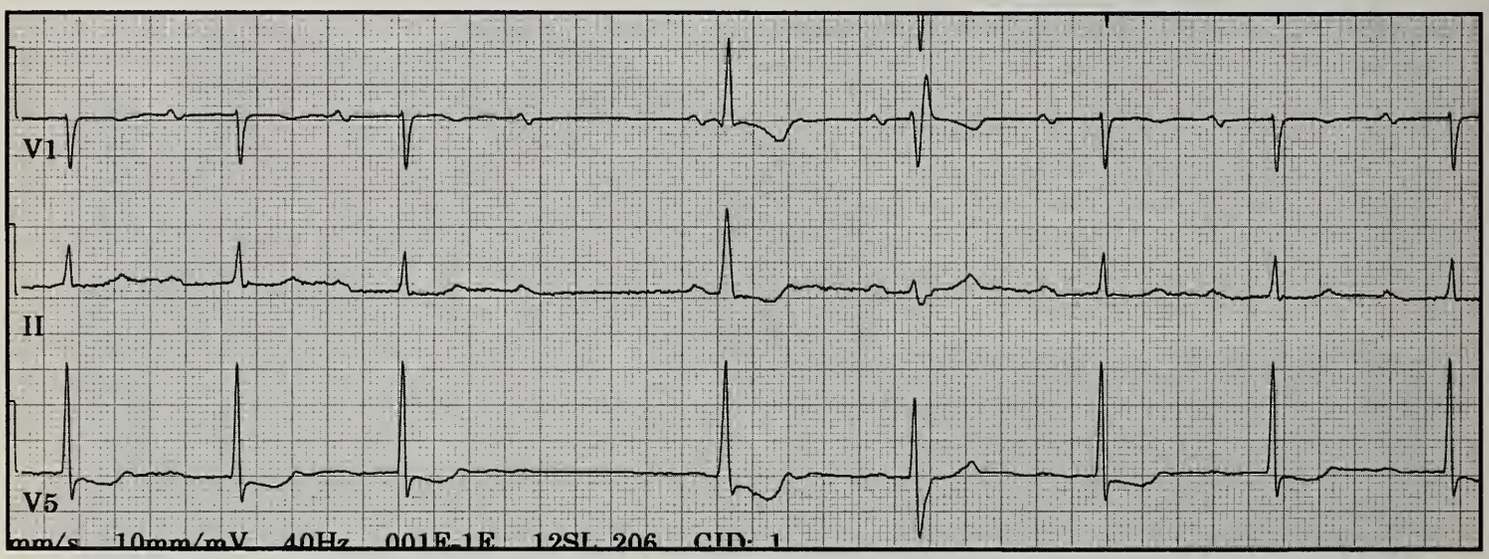
Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

This record was obtained from a 66-year-old man six weeks after a thoracotomy. His only medications were digoxin and quinidine. What is the rhythm? What is the mechanism of the AV block?



DISCUSSION:

Sinus rhythm with a rate of 53 BPM and minor sinus arrhythmia is present. The first two sinus complexes are conducted with PR intervals of 380ms and followed by normal QRS complexes. The third P wave is not conducted. The fourth P wave is followed by a narrow QRS complex (QRS duration = 100ms) with a PR interval of 160ms. The fifth P wave is conducted with a PR interval of 240ms and results in a QRS complex which is conducted with aberration. The sixth and subsequent P waves are followed by normal QRS complexes with PR intervals of 320ms.

The observation that the PR interval following the non-conducted P wave suggests that the II° AV block is Mobitz type I or Wenkebach block. The fact that the PR interval does not prolong after the third conducted complex indicates that this is so-called "atypical Wenkebach" block. However, "typical" Wenkebach is seldom seen at conduction ratios greater than 3:2. The QRS complex following the pause has a qR morphology in lead V1. This complex represents a fusion complex between a ventricular escape focus and conduction of the sinus impulse. That the complex is a fusion is suggested by several facts: 1) There are two impulses leading to ventricular depolarization, a sinus P wave with a PR interval of 160ms, and the possibility of a ventricular escape focus (escape rate of 33 BPM); 2) the horizontal plane axis of the complex is 180° from the normally conducted complex and a qR morphology indicate a ventricular origin of depolarization; and 3) the QRS duration is less than 120ms, which would not be seen with depolarization arising exclusively from a ventricular focus. The fifth QRS complex has a RBBB configuration due to the Ashman phenomenon, i.e., a QRS complex closing short RR interval following a long RR interval is conducted with aberration.

Thus, this ECG represents several interesting features: Atypical Wenkebach block, ventricular escape complexes with fusion, and aberration due to Ashman phenomenon. The patient had a serum digoxin level of 2.4 ng/ml confirming the suspicion that the AV block was due to digitalis excess.

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Medicine in the News

Health Care Access Foundation Update

As of October 1, 1992, the Arkansas Health Care Access Foundation has provided free medical service to 4,709 medically indigent persons, received 9,880 applications, and enrolled 20,588 persons.

The program has 1,504 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

6th Annual Boone County Fish Fry

Approximately 200 guests enjoyed the 6th Annual Boone County Appreciation Legislative Fish Fry held at the home of Dr. Mahlon and Kay Maris near Harrison.

The Governmental Affairs Committee of the Boone County Medical Society sponsors the event each year to show their appreciation to the legislators and other elected public officials. CEO's of most local businesses as well as leaders of all community organizations were included.

Special guests this year were Nikki and Dr. Larry Lawson, president of the Arkansas Medical Society; Barbara and Dr. Mike Moody, president of the Arkansas Academy of Family Physicians; Mr. David Wroten, AMS assistant executive vice president; Mr. Lynn Zeno, AMS director of Governmental Affairs; Mr. Mike Mitchell, AMS legal counsel; Mr. Ken LaMastus, AMS executive vice president; Dr. Charles "Shot" Rodgers, chairman of the AMS Governmental Affairs Council; Senator Jon Fitch; Representative Bob Watts; and Representative Billy Joe Purdom.

EMCfax: A Simple Inexpensive Solution

Over the past decade, significant progress has been made in enabling larger practices to communicate electronically with health insurers. Today many such practices are utilizing practice management and patient billing computer systems to improve their operations and submit insurance claims electronically.

While a majority of the larger practices have embraced this approach, many smaller groups and individual practitioners have found it difficult to justify the investment in programming, training, and computer equipment needed to support electronic media claims (EMC). Recognizing this problem, Arkansas Blue Cross and Blue Shield (ABCBS) has decided to introduce a new EMC capability specifically tailored to the unique requirements of primary care physicians and other small groups submitting approximately 300 or fewer claims per month - fax-based claim submission (EMCfax).

EMCfax is very similar to the mail-in submission process currently used by most smaller groups. After preparing the HCFA 1500 (12-90) claim form in the same manner as today, the provider simply faxes rather than mails the form to ABCBS for automatic processing.

The EMCfax process allows virtually any provider to submit claims electronically and to quickly realize significant time and cost savings.

To find out more about how to become a EMCfax submitter, providers should contact ABCBS at (501) 378-2008. They will provide additional information about how to obtain custom green fax claim forms, and how to enroll and quickly take advantage of this new capability, even if you do not own a fax machine.

CHAMPUS Preadmission/Preprocedure Authorization

As part of its regional contract with the Department of Defense, the Texas Medical Foundation reviews inpatient services provided to CHAMPUS beneficiaries in acute-care civilian hospitals and rehabilitation units, including hospitals participating in coordinated care networks and children's hospitals Arkansas.

While most of TMF's review activities are initiated through cases selections obtained from CHAMPUS fiscal intermediary claims data, preadmission/preprocedure review actually begins with the physician or his/her designee.

In preadmission/preprocedure review, TMF determines the medical necessity and appropriateness of the setting for inpatient admissions for selected principal diagnoses (except abortions; see code list) and for selected procedures, regardless of whether the procedure authorization applies regardless of whether the beneficiary's CHAMPUS coverage is primary or secondary.

For these selected diagnoses and procedures, the CHAMPUS program requires that a physician (or the

CHAMPUS Diagnoses and Procedures Which Require Preadmission/Preprocedure Authorization (effective 5/15/92)

Simple Pneumonia

485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia

Bronchitis/Asthma

466.0	Acute bronchitis
466.1	Acute bronchiolitis
490	Bronchitis, not specified as acute or chronic
491.0	Simple chronic bronchitis
491.9	Unspecified chronic bronchitis
493.00	Extrinsic asthma w/o status asthmaticus
493.10	Intrinsic asthma w/o status asthmaticus
493.90	Asthma, unspecified w/o status asthmaticus
493.01	Extrinsic asthma w/ status asthmaticus
493.11	Intrinsic asthma w/ status asthmaticus
493.91	Asthma, unspecified w/ status asthmaticus

Coronary Artery Bypass Graft

36.10	Aortocoronary bypass for heart revascularization, not otherwise specified
36.11	Aortocoronary bypass of one coronary artery
36.12	Aortocoronary bypass of two coronary arteries
36.13	Aortocoronary bypass of three coronary arteries
36.14	Aortocoronary bypass of four or more coronary arteries
36.15	Single internal mammary-coronary artery bypass
36.16	Double internal mammary-coronary artery bypass
36.19	Other bypass anastomosis for heart revascularization

Angioplasty/Endarterectomy

36.01	Coronary (balloon) (single vessel)
36.02	With thrombolytic agent infusion
36.05	Multiple vessels
38.12	Endarterectomy - head and neck

Cardiac Catheterization

37.21	Right heart cardiac catheterization
37.22	Left heart cardiac catheterization
37.23	Combined right and left cardiac catheterization
88.55	Coronary arteriography - single catheter
88.56	Coronary arteriography - two catheter
88.57	Other and unspecified arteriography

Gastritis/Dehydration

267.5	Dehydration
535.00	Acute gastritis w/o hemorrhage
535.30	Alcoholic gastritis w/o hemorrhage
552.3	Diaphragmatic hernia with obstruction
553.3	Diaphragmatic hemia
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Abortion

Two ICD-9-CM codes must be provided, one for the diagnosis and one for the procedure. Both codes must appear on the list of codes which require prior authorization; if not, the case does not require preprocedure review. The diagnosis code must be primary or secondary.

ICD-9-CM Diagnosis Codes

635.0x - .9x	Legally induced abortion
636.0x - .9x	Illegally induced abortion
637.0x - .9x	Unspecified abortion
638.0x - .9x	Failed attempted abortion
V61.7	Other unwanted pregnancy

ICD-9-CM Procedure Codes

69.01	Dilation and curettage for termination of pregnancy
69.02	Dilation and curettage following delivery or abortion
69.51	Aspiration curettage of uterus for termination of pregnancy
69.52	Aspiration curettage following delivery or abortion
74.91	Hysterotomy to terminate pregnancy

NOTE: CHAMPUS coverage for abortions is prohibited by law except where the life of the mother would be endangered if the fetus were carried to term.

physician's designee) call TMF to obtain a treatment authorization number prior to the physician's admitting the beneficiary or performing the procedure. The list of ICD-9-CM diagnosis and procedure codes which require preadmission/preprocedure authorization appear on the previous page.

Physician Responsibility

To receive a treatment authorization number for a selected diagnosis/procedure, the physician (or physician's designee) must call TMF prior to the admission, before the procedure, or within two working days of an urgent/emergency admission/procedure. The toll free number for TMF's preadmission/preprocedure authorization line is 1-800-299-8963. If the physician has any question regarding whether or not a diagnosis or procedure requires preauthorization, he or she is encouraged to call the TMF general inquiry number for CHAMPUS cases. The CHAMPUS general inquiry number is 1-800-299-8963.

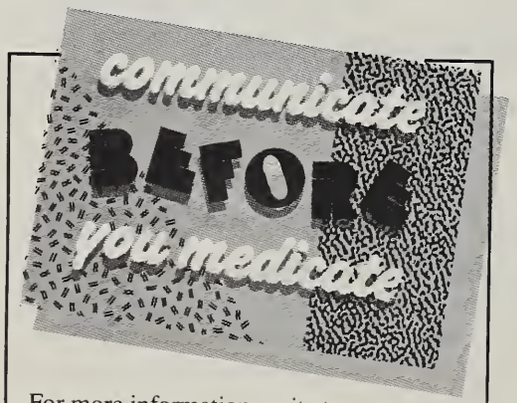
The physician (or designee) must give the following information to the TMF nurse reviewer:

- ✔ the beneficiary's full name, CHAMPUS identification number, age, and date of birth;
- ✔ hospital name and provider number;
- ✔ physician's name, UPIN number, and telephone number; and
- ✔ pertinent medical information which substantiates the beneficiary's medical need for the admission/procedure.

Preadmission/preprocedure authorization may be requested for an admission/procedure up to 30 days before the scheduled date. The treatment authorization number assigned by TMF remains valid for up to 30 days from the date the admission/procedure is originally scheduled.

The physician (or designee) must notify TMF if the hospital, surgical setting, or physician changes from what was originally submitted to TMF.. When the admission/procedure date, the original treatment authorization number is invalid. The physician (or designee) must call TMF to reinitiate review and consideration of a new treatment authorization number.

If a CHAMPUS admission/procedure takes place outside of this date window and TMF is not notified, the CHAMPUS fiscal intermediary will pay the claim but the case will be selected for TMF's retrospective review of the medical record. A canceled procedure does not have to be reported to TMF. Cases for which a treatment authorization number is not obtained as required will also be selected for retrospective review.



For more information, write to:
National Council on Patient Information and Education (NCPIE)
666 Eleventh Street, NW Suite 810 D
Washington, DC 20001
To fax your request — (202) 638-0773

In Memoriam

Robert Fudge Shannon, M.D.

Dr. Robert F. Shannon, a Little Rock psychiatrist, died Wednesday, September 30, 1992. He was 59.

Dr. Shannon served a three-year term as the State Commissioner of Mental Health and served more than 25 years on the faculty of the University of Arkansas for Medical Sciences, where he was a professor of pshchiatry and the first chief resident in psychiatry. He co-founded the Arkansas Psychiatric Clinic. He also founded the adolescent care unit at UAMS. Dr. Shannon was medical director of Professional Counseling Associates, past medical director of Pinnacle Point Hospital, and past director of the youth program at The Bridgeway Hospital.

Dr. Shannon was an 8th District Councilor of the Arkansas Medical Society and a member of the American Medical Association and the Pulaski County Medical Society.

Survivors are his wife, Carolyn; a daughter, Shawn; three sons, Scott, Jeff, and Tim; his mother, Mrs. Ollie Shannon Smith; and a sister, Mrs. Shannon Roe.

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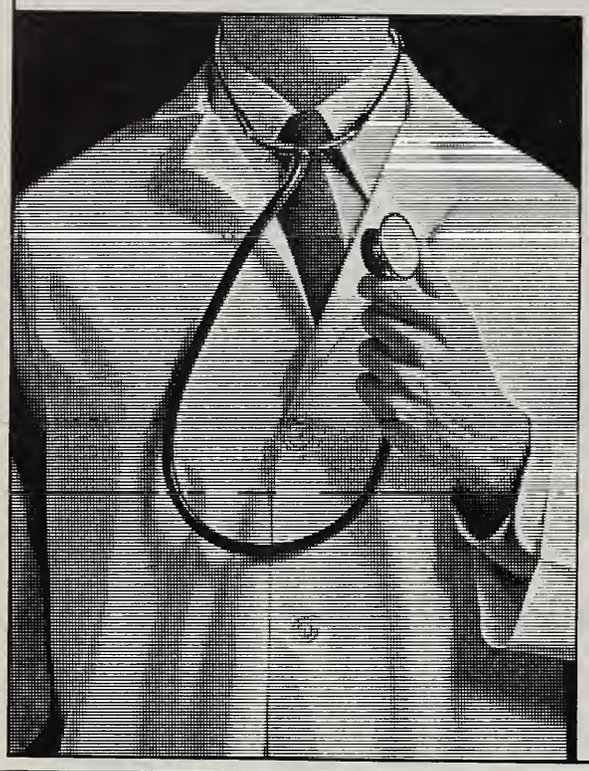

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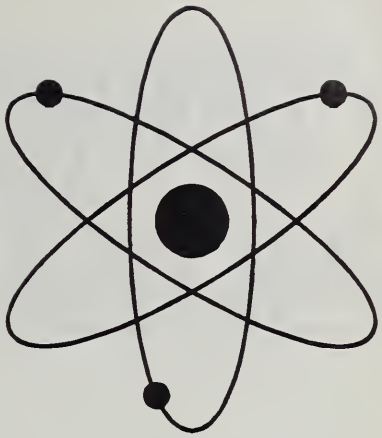
Radiological Case of the Month



David L. Harshfield, M.D.
Kelly Grigg

History:

Patient A (figure 1) presented with a a history of persistent abdominal pain after bowel surgery for resection of a segment of the sigmoid colon for diverticulitis. There was no elevated white count and the patient was afebrile with diffuse abdominal tenderness. Patient B (figure 2) had persistent abdominal pain after laparoscopic cholecystectomy and had this radiograph on post-op day two.

Figure 1. Patient A.

Figure 2. Patient B.

Small Bowel Obstruction - Patient A
Adynamic Ileus - Patient B

Findings:

Figure 1 shows distension of the small bowel with multiple air fluid levels seen in the central portion of the abdomen. There is no evidence of gas or air fluid levels in the distribution of the large bowel (peripheral). Figure 2 shows evidence of air in the large and small bowel, although, there is preferential distention with significant air fluid level formation in the small bowel (central).

Discussion:

One of the most difficult diagnoses to make on plain film is the distinction between small bowel obstruction and ileus. Both of the patients presented with a similar history, as well as clinical and physical findings. Patient A had a loop of small bowel entrapped in a closing suture which occurred at the end of the partial colectomy for diverticulitis. The patient was reoperated and demonstrated a portion of the small bowel was infarcted resulting in mechanical small bowel obstruction. Patient B, on the other hand, had undergone laparoscopic cholecystectomy and the radiographic picture demonstrated predominantly dilated loops of small bowel, however, there was also evidence of gas in the distribution of the colon making, at least, complete small bowel obstruction less likely. Early partial or intermittent small bowel obstruction can present with a similar disparity in the amount of gas seen in the small and large bowel. The patient was followed with sequential abdominal films and resolved the ileus five days after surgery.

Generally, complete small bowel obstruction (as classically demonstrated in the plain film of patient A) shows, exclusively, small bowel loops dilated with multiple air fluid levels, some of which are at different levels in the same loop of bowel (differential air fluid levels). Unfortunately, this classic appearance is not always present and abdominal radiographs are often times confusing because of patient body habitus, previous surgery, or degree of difficulty in obtaining well defined films since some have to be performed on a portable basis. The second case demonstrates very prominent small bowel distension in a patient with ileus. The fact that there was air in the colon was helpful, although, partial small bowel obstruction was suspected early on in the course of this patient's post operative care. By following the patient with serial x-rays, he was documented to resolve the adynamic ileus which is seen very commonly in patients who are post surgery, particularly in those who undergo general anesthesia.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.

Contributor: Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.

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Things To Come

November 19

Practice Review and Update of Infectious Disease. Allis Plaza Hotel, Kansas City, MO. Sponsored by the Department of Internal Medicine, Division of Infectious Disease, University of Kansas Medical Center. AMA Category I, American Academy of Family Physicians, and American Nurses Association credit hours available. For more information, call Mary Boyd at (913) 588-4488.

November 20-21

Hyperlipidemia. Sponsored by and held at the University of California, Davis, Medical Center, Office of Continuing Medical Education, Sacramento, CA. CME Category I credits available. For more information, call (916) 734-5390.

November 21

Hyperlipidemia. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine, Office of Continuing Medical Education, St. Louis, MO. For more information, call Cathy Caruso at (800) 325-9862.

January 8-9, 1993

15th Annual What's New in General Surgery. Hyatt Regency, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME Category I credit hours available. Fees: $285, physicians; $200, others. For more information, call (916) 734-5390.

January 17-19

Ambulatory Gynecology. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME Category I credit hours available. For more information, call (916) 734-5390.

January 24-30

19th Annual Midwinter Program for Physicians. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME Category I credit hours available. For more information, call (916) 734-5390.

February 5-6

11th Annual Infectious Disease Conference. Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME Category I credit hours available. For more information, call (916) 734-5390.

February 21-26

Emergency Medicine. Hyatt Regency, Incline Village (North Lake Tahoe), NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. Fees: $425/$325, past participant; $465/365, non-past participant. CME Category I credit hours available. For more information, call (916) 734-5390.

March 8-12

Radiation Safety Specialist Training Program. Oklahoma City, OK. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

March 10-13

Health Care '93. Sunshine City Exhibition Center, Ikeburuko, Tokyo. Sponsored by JETRO (Japan External Trade Organization). For more information, call JETRO-Houston (713) 759-9595.

March 13

Women's Health and Breast Cancer. University of California, Davis, Medical Center, Cancer Center Auditorium, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the UC, Davis School of Medicine and Medical Center. CME Category I credit hours available. For more information, call (916) 734-5390.

April 2-3

Ambulatory Pediatrics. Sacramento Inn, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME Category I credit hours available. For more information, call (916) 734-5390.

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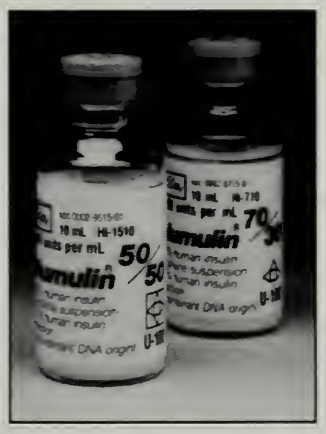

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Keeping Up

Estate Planning for Physicians

November 19, 6:30 p.m. - 9:00 p.m. and November 21, 9:30 a.m. - 12:00 noon, Holiday Inn Airport, Little Rock. Sponsored by the Arkansas Medical Society. Fees: $75.00, member physician; $15.00, member spouse; $100.00 non-member physician; $30.00, non-member spouse. For more information, call Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Arkansas Medical Society Fall Meeting

November 22, Holiday Inn Airport, Little Rock. Registration information and meeting times will be forthcoming. For more information, call Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Advanced Concepts in Electronic Fetal Monitoring

December 4, 7:30 a.m. - 3:30 p.m., UAMS Education II Building, Room G137, Little Rock. Sponsored by the UAMS College of Medicine. CME Category I credits available. Fees: Early registration - $10.00, employees and students; $20.00, all others; Late registration - $15.00, employees and students; $25.00, all others. For more information, call (501) 686-5261.

ATLS Instructor Course

December 5, 8:00 a.m. - 7:00 p.m.; December 6, 8:00 a.m. - 3:30 p.m., UAMS Education II Building, Little Rock. Sponsored by UAMS College of Medicine. Presented by Drs. Charles Mabry and Robert W. Barnes. CME Category I credits available. Fees: $575.00.

Family Medicine Spring Academic Conference

May 21-23, 1993, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

Update on Legal Issues and Risk Management

November 21, 8:30 a.m. - 12:00 noon, University of Arkansas Division of Continuing Education, Fayetteville. Sponsored by the Northwest Arkansas Hospital Association. Presented by Walter Cox, Attorney; Jill Reynolds, RN, professional liability manager; Tom Hesselbein, medical service division manager; and Mike Manoles, health care representative. CME Category I credits available. For more information, contact Allan March at (501) 575-4451.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, November 13 & December 11, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
GI Conference, 4th Friday, 11:30 a.m., Shuffield Auditorium
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Category 1 credits available. Lunch provided
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times monthly, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours

Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

Pediatric Advanced Life Support Course, December 11-12, AHEC
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st-4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

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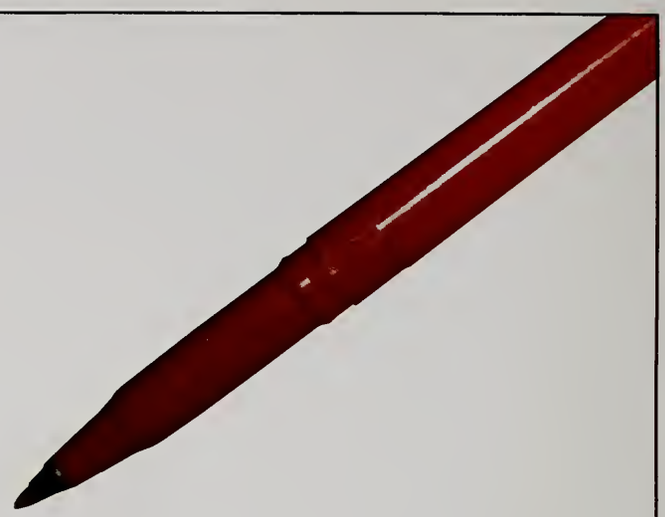

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Our cover photo originally appeared on the cover of the December 1991 issue of Kentucky Medicine.

The Health of Children in Foster Care

Sam Shultz, M.D.

It will come as no surprise to physicians seeing children in our state that one of our most medically underserved groups and with also the largest number of chronic health problems is the population in foster care. The news media has reacquainted us with the problems these children face both in their natural homes and in foster care.

The original intent of foster care was that the placement would be temporary while the biological family was aided by social service agencies and health professionals to improve the quality of life in that family. During this time, it is assumed that the child's medical and psychological needs are being met.[2]

However, foster care is routinely not a temporary experience. According to Gershenson, 25% of youngsters remain in foster care two years after placement, and of the children reunited with their families, 20% return to the foster care system within a year.[3] Given the estimate of over 400,000 in foster care annually, this is no significant number.

Additionally, approximately one-fourth of children are moved three or more times while in foster care.[1]

Likewise, the total health care needs of these children are not being met. Indeed, their problems would be difficult to meet under the best circumstances. Hochstat, Jaudes, et al reported their experience with 150 children entering foster care in the Chicago area in 1984. Fifty percent of the patients were in foster care because of neglect, a figure comparable with other studies.

Their study found only 13% of the children to have normal physical examinations. The most common conditions were growth failure (20%), cardiovascular (19%) and dental (14%). Thirty-four percent had potentially serious medical problems requiring at least one pediatric subspecialty consultation.

Developmental screening revealed delay in 38% of the children under five, and behavioral assessment screening were abnormal in 87% of children over four.[1]

The authors relate that their findings can not be attributed to low socioeconomic status alone. Several studies of low SES children in natural homes have found a markedly lower incidence of the above problems than did foster care children.[4]

Those who study the American foster care system relate that there has been little evidence of centralized planning to meet the health needs of these children. According to Schor, "the....planning represented within the Social Security Act and AFDC....has placed child welfare policy within a partisan process. P.L. 96-272 of 1980 encouraged permanency planning for foster children and provided federal funds for health care services for "hard-to-adopt" children. However, comprehensive health care for these very complex medical and psychological problems is generally not a high priority matter.[2]

As physicians caring for children, we could act as advocates for these patients with our elected representatives and state agencies. The following recommendations could be a goal of physicians - collectively and individually:

1. Early medical and psychological screening of each child entering foster care.

2. Designating a particular individual or agency to serve as the health care coordinator for each child. This could be the physician, nurse practitioner, public health nurse, social worker, etc. This is particularly important for those youngsters with chronic medical conditions, developmental or behavioral disorders.

3. Medical records which go with the child are imperative. The difficulty in treating this population is quite often compounded by our lack of knowledge of what other caregivers have done. Medical, dental, developmental/behavioral information must be available at all times.

4. Increased training and education for foster parents is necessary, especially for those who keep children with significant health problems. Physician - foster family education is vital in the office, but should not be the only source of information.

Attention to the health of those in foster care system can not be overemphasized. To quote Chadwick, "If we (as professionals) fail to provide the needed care, ...we may ensure that society has to continue to care for them as adults, in the penal system, the mental health system, or both."[5]

References

1. Hochstat NJ, Jaudes PK, Zimo DA. The medical and psychological needs of children entering foster care. Child Abuse and Neglect, 1987;11:53-62.

2. Schor EL. Foster Care. Pediatric Clinics of North America. December 1988;35:6.

3. Gershenson CP. Impact of P.L. 96-272. Child Welfare Research Notes. Administration for Children, Youth & Families, HDS, DDHS. March 1984.

4. Starfield B, Gross E, Wood M, et al. Psychosocial and psychosomatic diagnoses in primary care of children. Pediatrics, 1980;66:159-167.

5. Chadwick DL. The Health and Care of Foster Children. APSAC Advisor, 3-5, Spring 1992. ■

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A Qualified Response

Dear Dr. Langley:

This letter is written in response to the article published in the October 1992 issue of *The Journal of the Arkansas Medical Society* in which you were very critical of the actions of the Arkansas State Medical Board. Having served as secretary and a member of this Board for 42 years, I feel qualified to answer your "Letter to the Editor." Although, please understand this is not written with the consent or knowledge of any member of the Medical Board, since I have retired from that position.

I get the impression in your letter that you and one of your patients think that medical graduates of eastern medical schools are superior and better educated than physicians practicing in Arkansas. For the most part, the majority of physicians practicing in Arkansas are graduates of the University of Arkansas Medical School. Over the period of years that the FLEX and national board exams have been given by the Arkansas Board as their standard examination, graduates of the University of Arkansas Medical School have consistently made higher grades on these exams than graduates of medical schools of other states, including those from the east. There have always been fewer failures on these exams from Arkansas graduates than from applicants from other state schools. Certainly, one answer is due to the fact that the University of Arkansas, having only one medical school, can accept the cream of the crop from Arkansas schools and does not have to compete with other medical schools in their state.

This letter is not to approve or disapprove of the Board's action in your case, since I know nothing about the charges brought against you. The legislature wisely created the State Medical Board as an independent state agency which serves as a lower court and gives the disciplined physician the right to appeal to a higher court and eventually to the Supreme Court. Since you are dissatisfied with the Board's decision, you certainly are right in your appeal to a higher court. However, I might say, that in my 42 years as secretary, the Board never lost a case on appeal due to disciplinary action taken by the Board. You mentioned that four members of the Board voted against taking action against you. My opinion is that they were voting against the extent of the Board's punishment rather than approving your method of prescribing.

I am not worried about your fear of lack of progress in medicine or stagnation in practice of medicine in this state. Our graduates have proven by examination to be equal or superior to graduates of other schools, and Arkansas physicians provide medical care comparable to that provided by physicians in other states. I am much more worried about the great influx of physicians applying to practice in this state. Some of those, after investigation, have proven at best to be borderline physicians. However, I do want to impress that the majority of out-of-state physicians licensed by this Board have proven to be good physicians and have not had to appear before the Board. They provide the same high quality medical care as those who are Arkansas graduates.

If the grass is greener beyond this state, please tell me why you decided to come to Arkansas rather than to practice in the state from which you graduated and for the most part paid for your education? Please understand that there is nothing personal in this letter, and I wish you well. I just feel that it is my duty to set the record straight and to speak in behalf of the good physicians of Arkansas whose honesty, integrity, ability, and medical judgement I value so highly.

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Joe Verser, M.D., F.I.C.S., F.A.A.F.P.
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Diagnosis and Management of the Tethered Cord Syndrome

Frederick A. Boop, M.D.
Anthony Russell, M.D.
William M. Chadduck, M.D.

Tethering of the spinal cord can occur from a thickened filum terminale, scarring due to myelomeningocele repair, lipomas or diastematomyelia. The typical presentation is a lumbar cutaneous defect, enuresis, unexplained back or leg pain, foot deformities, leg length discrepancies or scoliosis. Spinal ultrasound in neonates and MRI in older children offers ready diagnosis. With laser and microneurosurgical techniques, repair of these defects is safe and effective. The authors recommend that any infant having a mid-line lumbar cutaneous abnormality, such as a hemangioma, lipoma, hair patch or dimple, be evaluated to rule out tethering of the spinal cord.

For years, children with spina bifida aperta were known to manifest deterioration in bowel and bladder function, as well as ambulatory ability, and to develop scoliosis and orthopedic deformity of the lower extremities. In the past such changes were thought to be the natural history of the disease. Even after Hoffman coined the term "tethered cord syndrome" in 1976,[1] many felt that the pathophysiology he described only applied to a tight filum terminale and had no relevance to the more severe forms of spina bifida. We now know that the tethered cord syndrome can occur secondary to any number of congenital abnormalities occurring within the spinal axis and the clinical manifestations may be varied.

Embryology

The trilaminar embryo develops by day 18 of gestation. At this point the embryo is composed of endoderm, mesoderm, and ectoderm. Shortly thereafter, the mesoderm releases factors which induce the differentiation of the overlying neuroectoderm, thereby forming the neural tube.[2] The anterior neuropore closes around day 24 and the posterior neuropore closes by day 28. Under normal circumstances, the vertebrae and skin close over the neuroectoderm at the same time. This process is completed during the first trimester, and spina bifida, a consequence of failure of normal development, also occurs early within the first trimester.

At the end of the first trimester, the spinal cord completely fills the spinal canal, terminating at the end of the sacrum. This is followed by a differential rate of growth between the vertebral elements and the neural elements such that the termination of the spinal cord migrates cephalad in relation to the vertebrae. By birth, the termination of the spinal cord, or conus medullaris, lies at L3. By six months following birth, the conus comes to rest between L1 and L2, where it normally can

* Dr. Boop is a professor of anatomy at the University of Arkansas for Medical Sciences and chief of neurosurgery at Arkansas Children's Hospital.
** Dr. Russell a resident with the department of neurosurgery at Arkansas Children's Hospital and UAMS.
*** Dr. Chadduck is chairman of the Children's National Medical Center in Washington, D.C.

be found throughout adulthood. The distal termination of the pia mater gives rise to the filum terminale, a fibrous band which normally anchors the conus medullaris to the end of the dural sac. The filum is generally slack enough to allow for flexion of the spine without stretching the distal portion of the spinal cord.

Under pathologic conditions, the filum may be abnormally thickened, containing elements of fat or cartilage, and may prevent rostral migration of the neural elements (figure 1). When this occurs, distal spinal cord function is compromised and clinical symptoms ensue, typically appearing in children following a growth spurt. Yamada and co-workers[3] have nicely demonstrated changes in spinal cord blood flow and metabolism following tethering of the spinal cord. These changes are usually dissipated over several of the lowest spinal segments and, if addressed early, are reversible. If the tethering persists, irreversible structural changes occur with loss of neurons and gliosis in the distal spinal cord.

Figure 1. T1 weighted sagittal MRI image of the lumbar spine. The black arrow denotes the level of the conus which is at the L3-4 interspace, whereas the normal position should be the L1-2 interspace. Also note dorsal displacement and thinning of the lumbar spinal cord.

Cutaneous Manifestations

In the case of the child born with a myelomeningocele (figure 2), one can easily visualize how tethering of the spinal cord might occur with truncal elongation. More commonly, the significance of subtle signs of underlying pathology, such as a tuft of hair (figure 3), cutaneous hemangioma (figure 4), or dimple above the gluteal cleft many be overlooked. The infant who is hospitalized for recurrent gram positive meningitis may be found to have a sinus tract connecting the spinal canal with the skin, a small pore within the gluteal folds being the only outward sign of the pathology underneath. In other cases, a subcutaneous mass may suggest an underlying lipomyelomeningocele, or fatty stalk which tethers the spinal cord to the subcutaneous fat (figure 5). In a recent review of 60 children undergoing tethered cord release at Arkansas Children's Hospital, one third had cutaneous signature marks, other than a myelomeningocele, suggesting the underlying pathology.

Figure 2. A meningocele sac typical of spina bifida cystica.

Symptoms

In the absence of cutaneous manifestations, children may develop clinical evidence of an underlying tethered cord as they grow and their trunk lengthens. The most common clinical presentation of such is the child who develops back or leg pain. This pain is often poorly localized, is persistent, and is made worse by exercise or by flexion of the spine. Persistent back pain in a child is virtually always a sign of underlying pathology and should never be attributed to attention seeking behavior. Another common presentation of the tethered cord is the child who either fails to toilet train or who is toilet trained for a period of time and begins to lose control again. If old enough to verbalize, a history of urinary or fecal urgency may be obtained. A broad based gait or loss of balance may be a clue to loss of proprioception secondary to tethering. Orthopedic deformities such as pes cavus, varus or valgus deformities, leg or foot length discrepancies, or chronic hip dislocations may also suggest a primary spinal cord problem. Scoliosis may result from primary spinal cord pathology including tethering and, if corrected early, may lead to reversal of the scoliosis.

Diagnosis

The most reliable way to establish the diagnosis of tethered cord is to maintain a high index of suspicion.

Figure 3. A midline lumbar hair patch, a common signature mark of underlying occult spina bifida.

Any infant born with a sacral dimple, cutaneous midline abnormality, or lower extremity deformity should be screened. Plain spine x-rays to rule out spina bifida occulta should be done in all cases, but may be unreliable in infants, in whom the laminae are cartilaginous and may be difficult to visualize. However, because of their immature boney elements, neonatal spinal cords may be well visualized by ultrasound, allowing for imaging of the conus medullaris, the central canal, and other anatomical features.[4]

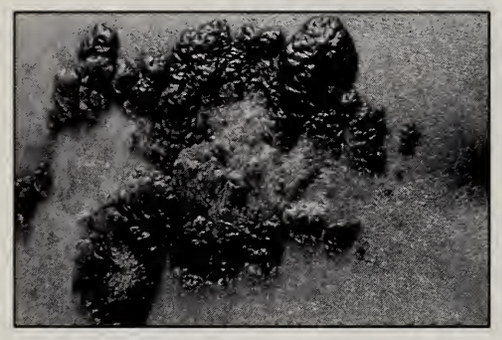

Figure 4. Cutis aplasia or hemangiomatous change in the skin over the midline just above the gluteal cleft. This signature mark is also a clue to an underlining dysraphic state.

In older children, plain spine x-rays may show spina bifida occulta, segmentation abnormalities, or even the boney spicule of diastematomyelia. Nonetheless, if the clinical situation raises suspicion of a tethered cord, the test of choice is Magnetic Resonance Imaging (MRI) of the spine. Myelography is now rarely required.

Electrophysiological tests may also be useful. Somatosensory evoked potentials may show progression of latency and loss of amplitude parallel to clinical symptoms and, if the tethered cord is released before permanent cord damage results, will return to baseline values. Electromyography may show changes consistent with chronic denervation, but is less useful.

The most common patient in whom we recognize symptoms of cord tethering comes from our myelomeningocele population. In this group, greater than ninety percent of the children have cerebral spinal fluid shunts. It should be emphasized that shunt dysfunction may mimic tethered cord symptoms and must always be ruled out prior to considering a detethering procedure. Having ascertained that the shunt is functional, at least 20% of children having undergone repair of a myelomeningocele at birth will develop a tethered cord.[5] In one recent study, twelve children enrolled in a spina bifida clinic underwent surgical detethering at the age of five years based only upon trunk growth. Seven of the 12 children were found to show improvement in gait, motor performance, or sensation following surgery.[6] Soon, a multi-center study will begin in order to determine more specific guidelines for detethering in this population.

Treatment

In children having spinal cord tethering secondary to a thickened filum terminale, surgery to section the filum is both safe and effective. The complication rate is less than 1% and blood transfusion is virtually never needed. Children who have diastematomyelia, or a boney spicule which splits the spinal cord, can also safely undergo removal of the lesion, thereby freeing the spinal cord. Children who are tethered by a lipoma infiltrating the spinal cord (lipomyelomeningocele) are repaired with laser vaporization of the fatty tissue at its point of attachment, and can now expect similar results with a very low rate of recurrence.[7]

Figure 5. Midline lumbar subcutaneous lipoma. This particular lipoma has skin tags, but the lipoma without skin tags is more common. Also note the cutis aplasia overlying the lipomatous mass. This lipomyelomeningocele.

In those cases of tethered cord undiagnosed until significant scoliosis or leg or foot deformity has occurred, further orthopedic correction may be necessary after repair of the underlying neurologic condition. Still, enough children have shown reversal of these changes (especially with scoliosis) following neurologic repair, that the spinal cord release should be undertaken in advance of orthopedic correction. Similarly, those patients presenting with bowel and bladder symptoms may show improvement following detethering, and urological procedures should be reserved for those who continue to be incontinent following release of their tether.

Conclusions

1. The tethered cord syndrome is common in children with spina bifida aperta (meningomyelocele), but also occurs in children with very subtle or absent cutaneous abnormalities.

2. In children with unexplained back or leg pain, leg length discrepancies, clubbed feet, scoliosis, or failure to toilet train, the diagnosis of tethered cord should be considered.
3. In newborn infants found to have cutaneous manifestations suggesting underlying abnormalities, ultrasound of the spine is an excellent screening tool. In older children and adults, MRI is the preferred imaging examination.
4. Early surgical correction of the tethered cord can be expected to alleviate pain in over 90% of children presenting with this symptom. Neurologic, orthopedic and urologic sequelae will stabilize in most cases. Moreover, if the correction is provided early enough, functional improvement may be anticipated.

References

1. Hoffman HJ, Hendrick EB, Humphreys R. The tethered cord syndrome. Its protean manifestations, diagnosis and surgical correction. *Child's Brain* 2:145-155, 1976.
2. Moore, KL. The nervous system in "The Developing Human: Clinically Oriented Embryology." WB Saunders Co., Philadelphia, 1977, pp 327-357.
3. Yamada S, Zinke DE, Sanders D. Pathophysiology of "tethered cord syndrome". *J Neurosurg* 54:494-503, 1981.
4. Glasier CH, Chadduck WM, et al. Screening spinal ultrasound in newborns with neural tube defects. *J Ultrasound Med* 9:339, 1990.
5. Begeer JH, Meihuizen de Regt MJ, Hogen EI, et al. Progressive neurological deficit in children with spina bifida aperta. Z Kinderchir 41(Suppl. 1):13-15, 1986.
6. Johnson MM. Associated spinal cord lesions with myelomeningocele (abstract). *Child's Nerv Syst* 3:321, 1987.
7. James HE, Williams J, Brock W, Kaplan FW, Hoi SU. Radical removal of lipomas of the conus and cauda equina with laser microneurosurgery. *Neurosurg* 20:469-472, 1984. ■

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The Relationship Between Life Expectancy and Socioeconomic Status in Arkansas: 1970 and 1990

David A. Swanson, Ph.D.*

Life Expectancy at Birth is estimated for county populations in Arkansas in 1970, 1980 and 1990. Counties are grouped into quintiles at each time point according to the percent of persons below the poverty level. Comparisons are made between mean life expectancy in the highest and lowest socioeconomic group at each point in time as well as between the same group at 1970 and 1990. It is hypothesized that the high socioeconomic populations will experience an increase in mean life expectancy over the low socioeconomic populations between 1970 and 1990. Statistical analysis supports the hypothesis. These findings conform to those from earlier research in Ohio and may reflect a continuing deterioration in the relative standard of living of lower income groups in the United States subsequent to 1970.

Remarkable progress has been made in reducing death rates during the 20th century. An important indicator of this progress is the reduction of infant mortality. Evidence indicates that by 1970, for example, not only had infant mortality been sharply reduced overall but that the persisient differential between higher and lower socioeconomic status populations had also been reduced.[1] However, by 1980 a sharp differential reappeared, which has been attributed to declines in relative living standards for lower middle and low socioeconomic status populations along with changes in national social policies supporting health care access for these groups.[1,2] This differential was expected to remain and even increase as these conditions persisted during the 1980's, which implies that populations of high socioeconomic status would experience an increase in life expectancy relative to populations of low socioeconomic status by 1990.

These findings and their implications provide a framework for this study of life expectancy at birth in Arkansas, which looks at county-level life expectancy differentials between populations in the highest socioeconomic group and the lowest socioeconomic group in 1970, 1980 and 1990. Using the research cited earlier, it is hypothesized that high socioeconomic populations will be found to have relative increases in life expectancy between 1970 and 1990 over low socioeconomic populations.

Methods and Data

The usual way to obtain life expectancy information is to construct a life table which has rigorous data requirements that are often diffucult to meet for many populations, including substate areas such as counties. However, a technique has been developed specifically for such populations that provides an accurate estimate

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of life expectancy using a regression equation and only two pieces of information about a population: (1) its crude death rate and (2) the percent of the population aged 65 years and over.[4] This equation, used in this study, is defined as follows:

$$eo = (1000)/((13.02763) + (.3201*M-.2007*M*logP65)^2)$$

where:

eo is life expectancy at birth
M is the crude death rate
log P65 is the base 10 logarithm of the percent of the population aged 65 years and over

The primary analytical unit is a county population. Data needed to generate life expectancy estimates for Arkansas counties were taken from vital statistics reports and census reports for 1970, 1980, and 1990, respectively.[5,6] A procedure often employed to dampen the effects of random variation on small area death rates is to take a three-year average centered on the year for which population (the denominator in a death rate) data are available. However, except under very limited conditions, such an average is biased with respect to the estimated death rate and unbiased alternatives are complicated.[7] Thus, a single years unbiased crude death rate was used.[4]

The percent of the population aged 65 years and over in each county is taken directly from census reports.[6]

Essentially the same procedure employed by Stockwell, Swanson, and Wicks[1,2] to classify small geographical areas by socioeconomic status in Ohio was used to classify Arkansas counties. In Arkansas, the percent of persons with income below the poverty level was found for each county from census reports.[8] For each year, 1970, 1980, and 1990, the counties were grouped into quintiles so that the highest quintile had the fifteen counties with the lowest percent of persons in poverty of all 75 counties and the lowest quintile had the fifteen counties with the highest percent of persons in poverty of all 75 counties. At each of the three decennial census years, 1970, 1980, and 1990 it is these two groups of counties, high socioeconomic status and low socioeconomic status, for which life expectancy figures are examined.

Statistical analyses are also conducted. Following considerations provided by Hays (pp. 424-425),[9] the T-test for independent groups is used to determine if two sets of counties share a common mean life same point in time. The one-tailed test is used at each time point since evidence indicates that life expectancy in the high socioeconomic status group is likely to exceed that in the low socioeconomic status group.[4] Likewise, the one-tailed T-test is used to test within each group between 1970 and 1990 because evidence indicates that life expectancy has been increasing over time.[4]

Results

The mean life expectancy levels in each of the two groups of counties for each of the three time periods are presented in Table 1 along with standard deviations. In 1970, the high and low socioeconomic status groups have the same mean estimated life expectancy, 70.9 years. As would be expected, the T-test result is not statistically significant, an indication that these two groups have the same mean life expectancy.

Mean life expectancy increased in the two groups between 1970 and 1980. For the high socieconomic group it increased 1.6 years to 72.5; for the low socioeconomic group it increased somewhat less, 0.8 years to 71.7. However, the T-test result for 1980 is not statistically significant, which again indicates that the two groups share a common mean life expectancy.

The mean 1990 life expectancy figure for the high socioeconomic status group is 72.9 which represents an increase over 1980 of 0.4 years. There is no change between 1980 and 1990 in mean life expectancy for the low socioeconomic group, it remains at 71.7 years. Here, the result of the one-tailed T-test is statistically significant ($T=2.48, p<.05, df=28$), which indicates that mean life expectancy for county populations in the high socioeconomic status group is higher than that for county populations in the low socioeconomic status group.

In terms of change over time, the mean 1990 and 1970 life expectancy values within each of the two socioeconomic status groups were subjected to the one-tailed T-test. In the high status group, the total change in life expectancy from 70.9 to 72.9 was statistically significant ($T=4.75, p<.05, df=28$), which indicates that improvement actually occurred. In the low socioeconomic status group, the result of the one-tailed T-test was not statistically significant: no improvement occurred.

Discussion

In accordance with the hypothesis, it appears that high socioeconomic populations have obtained increased life expectancy relative to low socioeconomic populations between 1970 and 1990. Although these results are specifically for counties in Arkansas, they are in accordance with the results and conclusions based on both the infant mortality research cited earlier, which was conducted for substate areas in Ohio from 1960 to 1980,[1,2,3] and the substate life expectancy research, also conducted using data from Ohio prior to 1990.[4,10] Stockwell, Swanson, and Wicks[1,2] argued that declining relative standards of living for the lower middle and lower socioeconomic status populations along with national policies that limited access to health care for these populations are likely to be factors contributing to a lack of improvement in mortality differentials subsequent to 1970. Although there are random and systematic errors as well as confounding factors that poten-

Table 1. Mean Life Expectancy at Birth for High and Low Socioeconomic Status Populations Arkansas, 1990, 1980, 1970

		1990	1980	1970
High Socioeconomic Populations*	mean	72.90	72.50	70.90
	s.d.	1.10	1.25	1.13
Low Socioeconomic Populations*	mean	71.70	71.70	70.90
	s.d.	1.44	1.68	1.68

* The county populations in each group by year are listed along with their individual estimated life expectancy values (in parantheses).

High Socioeconomic County Populations
(1st Quintile, lowest percent of persons in poverty)

1990	1980	1970
Baxter (76)	Baxter (76)	Benton (70)
Benton (74)	Benton (73)	Boone (72)
Boone (73)	Craighead (72)	Carroll (73)
Calhoun (72)	Crawford (72)	Craighead (71)
Carroll (74)	Faulkner (72)	Faulkner (71)
Conway (73)	Garland (74)	Grant (71)
Crawford (72)	Grant (72)	Hot Springs (71)
Faulkner (73)	Howard (73)	Howard (71)
Grant (73)	Independence (72)	Miller (68)
Lonoke (73)	Perry (72)	Pulaski (70)
Pope (73)	Pope (71)	Saline (72)
Pulaski (72)	Pulaski (71)	Sebastian (71)
Saline (72)	Saline (72)	Sevier (70)
Sebastian (72)	Sebastian (72)	Washington (71)
Washington (73)	Washington (73)	Yell (71)

Low Socioeconomic County Populations
(5th Quintile, highest percent of persons in poverty)

1990	1980	1970
Chicot (72)	Bradley (74)	Chicot (71)
Crittenden (71)	Chicot (72)	Cleburne (72)
Desha (71)	Crittenden (70)	Crittenden (68)
Fulton (74)	Desha (71)	Desha (71)
Jackson (73)	Lafayette (73)	Fulton (74)
Lafayette (72)	Lee (69)	Lafayette (70)
Lee (71)	Lincoln (72)	Lee (70)
Lincoln (73)	Mississippi (70)	Lincoln (72)
Mississippi (71)	Monroe (72)	Monroe (69)
Monroe (71)	Newton (75)	Newton (71)
Newton (74)	Phillips (70)	Phillips (70)
Phillips (69)	St. Francis (70)	St. Francis (70)
St. Francis (70)	Searcy (73)	Searcy (73)
Searcy (73)	Stone (72)	Stone (73)
Woodruff (71	Woodruff (72)	Woodruff (69)

tially affect these results (race and gender for example)[10,11] the results suggest that like their Ohio counterparts between 1960 and 1980 in regard to infant mortality, high socioeconomic status populations in Arkansas appear to have enjoyed both an absolute increase in life expectancy between 1970 and 1990 and a relative increase over low socioeconomic populations during the same period.

Because of the nature of the findings, it is fitting to conclude with the observation made by Stockwell, Swanson and Wicks in regards to infant mortality in Ohio[2] (p.326): "In an era when good health and access to good health care is seen as a basic human right for all our citizens, and not just an expensive privilege for those who can afford it, the continued failure of the existing health care delivery system to pentrate fully through to the lowest economic classes poses a major challenge for society."

Acknowledgment

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References

1. Stockwell EG, Swanson DA, Wicks JW. Temporal variations in the relationship between infant mortality and economic status. Social Indicators Research, 1988;20:217-227.
2. Stockwell EG, Swanson DA, Wicks JW. Trends in the relationship between infant mortality and socioeconomic status. Sociological Focus, 1987;20(4):319-327.
3. Stockwell EG, Bedard ME, Swanson DA, Wicks JW. Public policy and the socioeconomic mortality differential in infancy. Population Research and Policy Review, 1987;6:105-121.
4. Swanson DA, Stockwell EG. Geographic variation of longevity in Ohio, 1930 and 1980. Ohio Journal of Science, 1986;86(4):144-149.
5. U.S. Bureau of the Census (1970, 1980, 1990) General Population Characteristics, Arkansas. Washington, D.C.: Government Printing Office.
6. Arkansas Department of Health (1970, 1980, 1990) Arkansas Vital Statistics, Center for Health Statistics. Little Rock: Arkansas Department of Health.
7. Palit CD, Krebs HC. An investigation of the conditions affecting the accuracy of censal ratio estimates. Technical Series 70-1. Applied Population Laboratory, Department of Rural Sociology, University of Wisconsin, Madison, 1977.
8. U.S. Bureau of the Census (1970, 1980, 1990) General Social and Economic Characteristics, Arkansas. Washington, D.C.: Government Printing Office.
9. Hays WL. Statistics for the Social Sciences, 2nd Edition. Holt, Rinehart, and Winston. New York, 1973.
10. Swanson DA, Stockwell EG. Are geographic effects on life expectancy in Ohio spurious because of race? Ohio Journal of Science, 1988;88(3):116-118.
11. Keil JE, Sutherland SE, Knapp RG, Tyroler HA. Does equal socioeconomic status in black and white men mean equal risk of mortality? American Journal of Public Health, 1992;82(8):1133-1136. ■

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Frank Snell*

Nobel prize winner Max Planck said, "A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it." As with many of the para-medical fields, prosthetic technology is advancing into the future with the aid of computer innovation. Today's prosthetist has at his fingertips the ability to treat the amputee patient with never before possible techniques that will help insure the design, fit and fabrication of the finest "state of the art" prosthesis. Chief among these techniques is Computer Aided Design-Computer Aided Manufacture (CADCAM) system of prosthetics.

The field of prosthetics today is a mixture of mature, skilled craftsmen, many of whom were grandfathered into certification in the post World War II years, and younger, college trained clinicians. Both groups are challenged by the progress of technology and the excitement that it offers. Many are now pursuing CADCAM prosthetic technology as an alternative to the traditional ways of the craftsmen.

In conventional prosthetic fabrication methods, all of the measuring, casting and fitting is a "hands-on" process. Linear and circumferential measurements are taken of the patients amputated limb and a plaster of Paris mold is wrapped directly over the residual limb. This negative mold is separated from the patient and filled with a plaster of Paris mixture, that, after hardening, leaves a solid positive plaster model. This model is then carved by hand by the prosthetist to produce a modified shape that will be suitable for weight bearing, relieving pressure from the sensitive bony areas and loading pressure on the tougher areas. From this modified mold the prosthetic socket is then fabricated.

By using the sophisticated CADCAM method, this process is greatly improved. The components of the CADCAM system are the Central Processing Unit (CPU) (figure 1), the Digitizer (figure 2) and the Computer Numeric Carver (figure 3). To begin the procedure, the prosthetist takes the standard plaster of Paris cast and necessary measurements, but instead of filling the mold in the usual manner, it is secured into the digitizing device which will probe the interior dimensions of the mold from distal to proximal and store them in the digitizer memory. In this process, measurements are recorded at 10 degree intervals; 36 in each circle before the probe moves proximally 1/4" and completes the next circumferential pass, making 36 more readings. This process is repeated until the probe reaches the proximal edge of the cast. Over the length of an average 10 inch mold, 1440 readings are taken and stored in the memory bank of the digitizing unit.

* Mr. Snell is a certified prosthetist orthotist and is president of Snell Laboratory. Snell Laboratory, founded in 1911, is the largest prosthetic and orthotic laboratory in Arkansas and is the only fully computerized prosthetic and orthotic laboratory in the state. Offices are located in Little Rock, Fort Smith, Russellville and Mountain Home.

Once the digitizing probe has completed the necessary measurements, the information is saved in the CPU where the digitized shape can be displayed on the computer monitor. During this procedure, the conventional "hands on" modification becomes a computer task, as a three dimensional computer image undergoes transformation as length and circumferential measurements, as well as regional shape changes are performed on the image. The shape can be modified in every way possible and viewed in every plane and cross-section imaginable. A particularly difficult area can be magnified to many times its normal size to allow the ultimate decision to be made by the prosthetist concerning the configuration of that area. When the process is finished and all of the many regions properly treated, the data is saved on the hard disk and can be recalled for examination or alteration at any time.

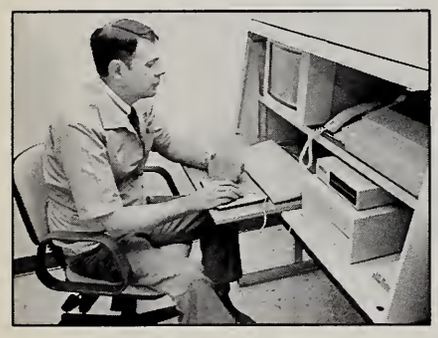

Figure 1. Central Processing Unit.

With the modification complete, the stored data is sent to the computer controlled carver, and the modified positive model is carved from a pre-formed tapered plaster of Paris blank by the carver. The carver can be programmed to carve on a radius of 1/4", 1/8", or 1/16", whichever is the preference of the prosthetist. A typical below the knee model can be carved in a matter of 20-30 minutes which will free up the prosthetist to go on to other projects making his time increasingly more efficient.

Figure 2. Digitizer.

Now that the positive model has been carved and prepared for fabrication, the transparent test socket is vacuumed formed over the model using Vivak, a clear thermoplastic material, and trimmed for fitting on the patient (figure 4). The test socket is placed on the patient and carefully evaluated for fit and function by communication between the patient and prosthetist. If it is determined that a second test socket is necessary, the prosthetist simply returns to the CPU and makes the necessary and usually minor modifications to the patient's 3-D image. A new mold and test socket are then produced in a few minutes. A computer experienced prosthetist is able to take a patient through consultation, evaluation, casting and measuring to fitting of the initial transparent test socket in less than three hours.

Figure 3. Computer Numeric Carver.

From a personal standpoint, I can attest to the high degree of accuracy and efficiency of the CADCAM system. Our staff has successfully fit 340 prostheses using this "state of the art" prosthetic technique in the last 18 months. Our patients are pleased with the comfort of their prostheses as well as the increased efficiency of the procedure. The fitting can now be accomplished in fewer patient visits and fewer return visits for adjustments and follow-up care. The learning curve for the software techniques and to become familiar with the high-tech equipment will vary from prosthetist to prosthetist, but this should not be a deterrent to an investment that will benefit the patients we serve. I have been a practicing prosthetist for over 20 years and have no desire to return to the procedures of the 1970's. My patients are very pleased with the fit and function of their prostheses utilizing the CADCAM system and I am extremely satisfied to be involved in advancing my profession into the 21st century.

Figure 4. Transparent Test Socket.

Acknowledgement

Special thanks to Dr. Leighton Millard for his assistance with this article. Dr. Millard is a retired orthopedic surgeon who has practiced for over 25 years. He is associated with Little Rock Orthopedic Clinic. ■

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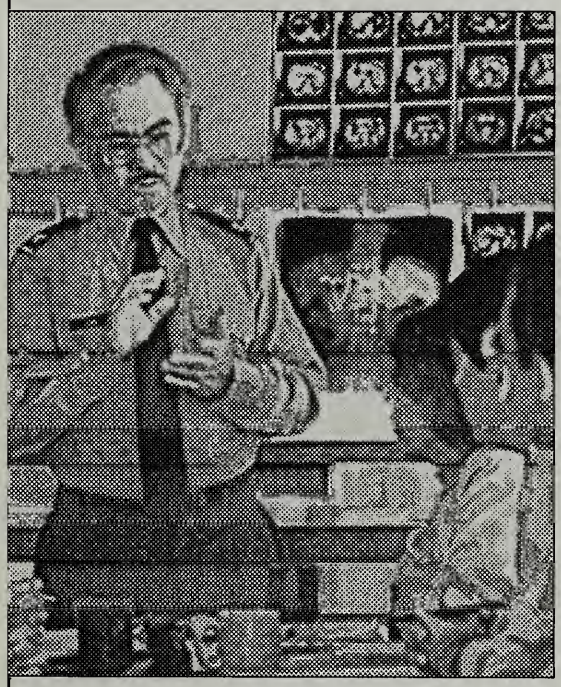

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Robert Booth Moore Sr.

Edwina Walls, M.L.S.*

An Arkansas native who continued the tradition in medicine of his grandfather, Dr. Robert Booth Moore Sr., was born at Searcy, Arkansas on July 22, 1888, the son of Dr. Luther E. and Martha Booth Moore. He was the oldest of three sons.

His undergraduate studies were done at Hendrix College and Vanderbilt University. He received his M.D. from the College of Physicians and Surgeons, Columbia University, New York in 1914. His internship was done at the Central and Neurological Hospital, Welfare Island, New York. He spent an 18 month residency in "eye, ear, nose and throat" at the Polyclinic Medical School and Hospital and a 12 month residency in the same field at Bellevue Hospital, both located in New York, New York. He received his license to practice in 1916 and his certification by the American Board of Otolaryngology was achieved in 1927.

Dr. Moore served as an officer in the Army Medical Corps in France and Germany during World War I. After the war, he had a solo practice in Little Rock for a short time before becoming an associate of Drs. Ogden, Judd, and Zell in 1921. He was one of the five founders of Trinity Hospital in 1923 and was the head of the Ear, Nose and Throat Department at Trinity from its inception. The staff of Trinity affectionately referred to Dr. Moore as "the little feller" probably because of his small stature. Norma O'Neal, the excellent dietitian at Trinity, was a cousin by marriage of Dr. Moore's. She had a reputation for delicious food served on flower bedecked trays which was an indication of the quality of care provided there.

Dr. Moore was a member of the Pulaski County and the Arkansas Medical Societies until his resignation precipitated by the Trinity Hospital controversy in 1931. Unfortunately, the controversy was not resolved prior to his death in 1945. However, he was a member of his specialty organization, the American Academy of Ophthalmology and Otolaryngology.

Dr. Moore married Lena Belle Barber in December 1933 in Little Rock. Their two sons, Robert Booth Moore Jr., M.D. and William Edgar Moore, Ph.D., were born at Trinity Hospital. Dr. Moore Jr. is currently an internal medicine specialist in Little Rock, and Dr. William Edgar Moore is a psychologist at the University of Michigan.

At the time of Dr. Moore's death on August 12, 1945, the family resided at 1820 North Monroe. His death occurred at Barnes Hospital in St. Louis of lymphosarcoma.

References

1. Arkansas Historic Quarterly 4 (Winter 1945), 370.
2. Herndon DT. Centennial History of Arkansas (Chicago, Little Rock, 1922) 2:101-102.
3. "Dr. Robert B. Moore of Trinity Dies," Arkansas Gazette (Little Rock, Arkansas), August 13, 1945.
4. Directory of Medical Specialists Certified by American Boards. (New York: Columbia University Press, 1942), 872.
5. Interview with Josephine Reynolds, R.N., October 14, 1981, Little Rock, Arkansas.
6. Interview with Mrs. James M. Stafford Jr., September 15, 1992, Little Rock, Arkansas. ■

* Ms. Walls is the head of the Special Collections Department of the University of Arkansas for Medical Sciences Library in Little Rock, Arkansas.

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Arkansas HIV/AIDS Report 1983-1992

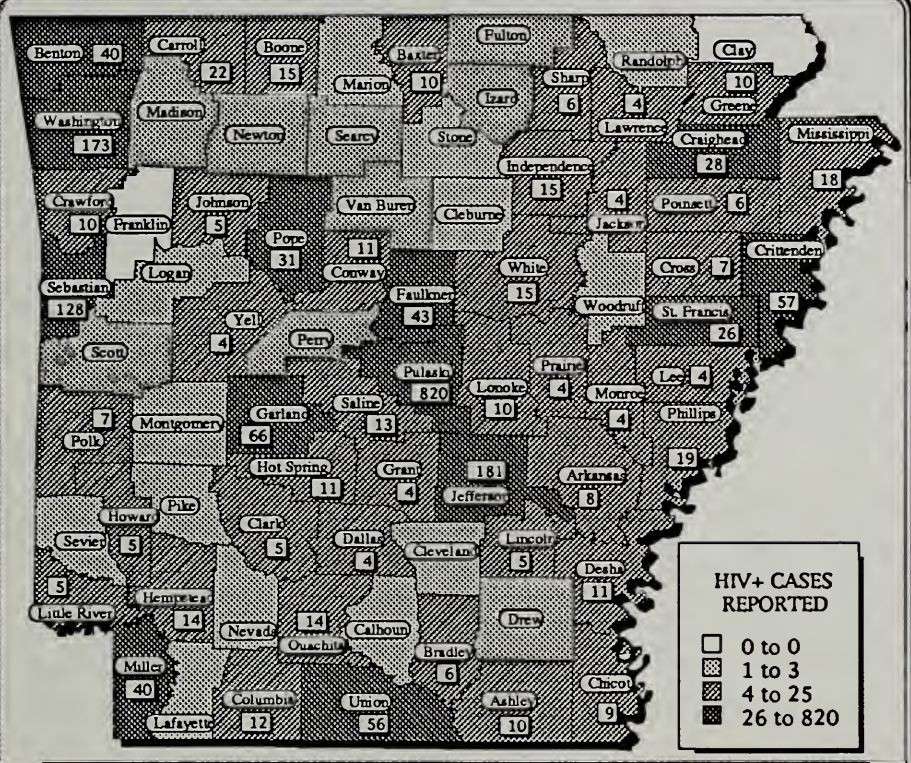
Arkansas: 1983 through October 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	437	421	352	1,777	85.47
	Female	1	1	6	27	39	72	89	67	302	14.53
AGE	< 5	0	0	1	1	2	9	14	5	32	1.54
	5-12	0	0	0	1	1	5	2	0	9	0.43
	13-19	0	0	0	8	8	14	20	23	73	3.51
	20-29	8	10	15	109	125	192	154	136	749	36.03
	30-39	7	15	22	86	105	206	219	163	823	39.59
	40-49	4	7	11	24	35	62	73	59	275	13.23
	> 49	1	1	6	6	12	19	23	32	100	4.81
	Unknown	0	0	0	8	2	2	5	1	18	0.87
RACE	White	16	24	47	171	178	353	312	261	1,362	65.51
	Black	4	9	8	70	107	153	195	149	695	33.43
	Other	0	0	0	2	5	3	3	9	22	1.06
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	419	2,079	100%

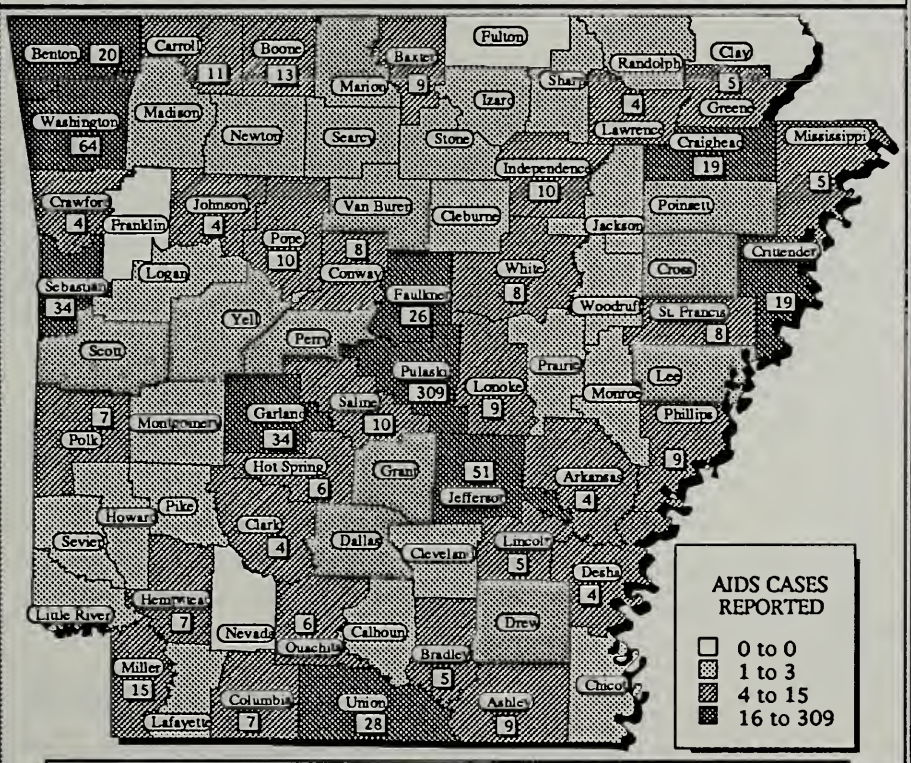
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	206	784	89.19
	Female	1	0	4	6	10	20	25	29	95	10.81
AGE	< 5	0	0	0	1	1	6	6	2	16	1.82
	5-12	0	0	0	1	0	1	1	0	3	0.34
	13-19	0	0	0	0	0	4	3	2	9	1.02
	20-29	7	9	15	27	24	55	57	64	258	29.35
	30-39	3	13	23	36	41	78	80	108	382	43.46
	40-49	1	6	8	10	7	35	41	43	151	17.18
	> 49	1	0	4	8	7	11	13	16	60	6.83
RACE	White	9	22	43	61	58	141	134	169	637	72.47
	Black	3	6	7	20	21	47	66	63	233	26.51
	Other	0	0	0	2	1	2	1	3	9	1.02
RISK	Male/Male Sex	7	17	31	59	50	118	118	142	542	61.66
	Injection Drug User (IDU)	0	2	10	4	11	18	28	29	102	11.60
	Male/Male Sex & IDU	3	9	4	6	6	18	17	14	77	8.76
	Heterosexual	2	0	2	3	6	10	10	17	50	5.69
	Transfusion	0	0	2	7	3	7	11	3	33	3.75
	Perinatal	0	0	0	1	1	6	6	2	16	1.82
	Hemophiliac	0	0	0	1	1	5	5	3	15	1.71
	Undetermined	0	0	1	2	2	8	6	25	44	5.01
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	235	879	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



County of residence at the time of test for the 2,079 Arkansans reported to be HIV+. (10/25/92)



Of the 2,079 Arkansas reported to be HIV+, 879 have been diagnosed with AIDS. (10/25/92)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

BENTONVILLE

Wachs, Theodore J., Psychiatry. Born, 2/12/34. Medical education, Creighton University School of Medicine, Omaha, NE, 1958. Internship, St. Joseph Hospital, St. Paul, MN, 1959. Residency, Wilford Hall USAF Medical Center, Lackland AFB, TX, 1977. Board certified.

EL DORADO

Dixon, Rodney M., Family Practice. Born, 12/23/55. Medical education, UAMS, 1982. Internship/residency, AHEC South, El Dorado, 1985. Board certified.

FORT SMITH

Aucar, John A., General Surgery, Vascular Surgery & Endoscopy. Born, 9/25/60. Medical education, University of Kansas School of Medicine, Wichita, 1986. Internship, Santa Barbara Cottage Hospital, 1985. Residency, Michigan State University, 1992.

Chosney, Bruce T., Medical Oncology & Hematology. Born, 11/10/42. Medical education, University of Virginia, 1968. Internship, Emory University Hospital, 1969. Residency, Los Angeles County, USC Medical Center, 1974. Fellowship, University of Michigan Hospital & Simpson Memorial Institute, Ann Arbor, MI, 1976. Board certified.

Cook, Charles D., Family Practice. Born, 4/10/47. Medical education, University of Oklahoma, Oklahoma City, 1973. Internship/residency, Memorial Medical Center, Corpus Christi, TX, 1974. Board certified.

Linzman, Roo F., General Practice. Born, 12/16/50. Medical education, Oklahoma State University, Tulsa, 1981. Internship, Hillcrest Health Center, 1982.

HELENA

Sorsby, Stephen C., Family Practice. Born, 12/16/57. Medical education, UAMS, 1983. Internship/residency, Madigan Army Medical Center, Tacoma, WA, 1986. Board certified.

HOT SPRINGS

Jackson Jr., Haynes G., OB/GYN. Born, 9/30/44. Medical education, UAMS, 1974. Internship/residency, UAMS, 1978.

JONESBORO

Lewis, David M., Otolaryngology - Head & Neck Surgery. Born, 6/22/55. Medical education, University of Utah School of Medicine, Salt Lake City, 1984. Internship/residency, University of Louisville, 1989. Board certified.

LITTLE ROCK

Hickerson, Steven L., Infectious Diseases Fellowship. Born, 8/15/60. Medical education, Texas Tech University, Lubbock, 1988. Internship/residency, UAMS, 1992.

Ketcham, Jeffrey K., Anesthesiology. Born, 5/30/59. Medical education, Southern Illinois University School of Medicine, Springfield, 1985. Internship, Southern Illinois University School of Medicine, 1986. Residency, University of North Carolina, Chapel Hill, 1990. Board certified.

Petrus, Gary M., Otolaryngology - Head & Neck Surgery. Born, 8/30/61. Medical education, UAMS, 1987. Internship/residency, UAMS, 1992. Board eligible.

Shah, Hemenora R., Diagnostic Radiology. Born, 11/25/45. Medical education, BJ Medical School, Ahmedahad, India, 1970. Internship, Bronx Lebanon Medical Center, NY, 1977. Residency, Newark Beth Israel Medical Center, NJ, 1987. Board certified.

Tobler, H. Gareth, Cardiothoracic Surgery. Born 9/14/51. Medical education, University of Minnesota, Minneapolis, 1976. Internship, University of Minnesota, 1987. Residency, Stanford University Medical Center, Palo Alto, 1990. Board certified.

MARIANNA

Webber, David L., Family Practice. Born, 8/16/56. Medical education, West Virginia School of Osteopathic Medicine, Lewisburg, 1988. Internship, Muskegon General Hospital, MI, 1989. Residency, Medical College of Ohio, Toledo, 1991.

NORTH LITTLE ROCK

Shotwell, Monica R., Psychiatry. Medical education, Santo Tomas University, Manila, Philippines, 1981. Internship, Santo Tomas University, Manila, Philippines, 1982. Residency, Baylor College of Medicine, Houston, 1988. Board certified.

OZARK

Doyle, Edward T., Family Practice. Born, 5/6/34. Medical education, New York Medical College, New York City, 1961. Internship, Easton Hospital, PA, 1962. Board certified.

Purvis, Quinnon R., Family Practice. Born, 12/6/35. Medical education, University of Florida College of Medicine, Gainesville, 1963. Internship, Union Memorial Hospital, Baltimore, MD, 1964. Board certified.

SEARCY

O'Mara, Steven G., Emergency Medicine. Born, 10/20/54. Medical education, Texas College of Osteopathic Medicine, Fort Worth, 1985. Internship/residency, USAF Medical Center, Scott, Belleville, IL, 1988. Board certified.

TEXARKANA

Salter, William R., OB/GYN. Born, 11/1/60. Medical education, Texas Tech University, Lubbock & El Paso, 1988. Internship/residency, University of Kentucky, 1992.

OUT-OF-STATE

Downes, John M., Psychiatry, Thousand Oaks, CA. Born, 6/7/54. Medical education, UAMS, 1980. Internship/residency, Wright State University/Wright-Patterson AFB, Dayton, OH, 1984. Board certified.

RESIDENTS

Cooper, Jesse E. Born, 10/7/61. Medical education, UAMS, 1992. Internship/residency, UAMS.

Frazier, Ronald K. Born, 1/19/57. Medical education, Texas A&M, Temple, 1991. Internship/residency, UAMS.

Hardy, Ross A. Born, 4/26/64. Medical education, UAMS, 1992. Internship, UAMS.

Holman, Douglas C., Anesthesiology. Born, 7/19/63. Medical education, UAMS, 1991. Internship/residency, UAMS.

MEDICAL STUDENTS

Adams, Jason H.
Dale, Casey S.
Froman, Elizabeth A.
Hartman, Richard R.
Hendrix, Barry D.
Johnson, Brad D.
Kendrick, Gregory A.
Lunsford, Richard
McKelvey, Kent D.
Merritt, Mathew M.
Moix Jr., Frank M.
Nguyen, Dzuy T.
Richey, Jason D.
Smith, Whitney D.
Stewart, Jason G.
Stout, Michael D.
Wornock, John P.

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The members of the Order of Merit set the example for their colleagues, orthopaedic industry and the public. They demonstrate the power of philanthrophy in expanding knowledge in orthopaedics for the relief of human suffering. Following is the Arkansas Roster of the 1991 Members, including all orthopaedists from Pine Bluff which has, thereby, been designated a "City of Merit."

-Banks Blackwell, M.D., Medical Director -

James A. Arnold, M.D., Fayetteville
Mr. Michael M. Bailey, Little Rock
Banks Blackwell, M.D., Pine Bluff
(A Memorial Tribute to Lyman Smith, M.D.)
Charles A. Clark, M.D., Pine Bluff
Robert R. Gullett, Jr., M.D., Pine Bluff
(A Memorial Tribute to Richard LeBlanc, M.D.)
Dr. & Mrs. Peter J. Irwin, Fort Smith
Philip H. Johnson, M.D., Little Rock
Dr. & Mrs. James M. Kolb, Jr., Russellville
Dr. & Mrs. Charles A. Ledbetter, Harrison
(A Tribute to Donald B. Kettelkamp, M.D.)
John O. Lytle, M.D., Pine Bluff
Dr. & Mrs. Bruce L. Smith, Jr., Hot Springs
J.L. Vander Schilden, M.D., Little Rock
(A Memorial Tribute to Richard Webber, Ph.D.)

AMS Newsmakers

Dr. Simmie Armstrong, a family physician from Pine Bluff, has been elected parliamentarian of the Southeast Arkansas Medical, Dental and Pharmaceutical Association.

Dr. Robert Baker, a gynecologist from Mountain Home, has been named chairman of the CARTI Mountain Home Advisory Board. Dr. Baker also serves on the board of directors of CARTI in Little Rock.

Dr. Hugh F. Burnett, a thoracic surgeon from Little Rock, has been elected secretary of the Arkansas chapter of the American College of Surgeons.

Dr. John G. Elders, a family physician from Mountain Home, has been named a diplomat of the American Board of Family Practice.

Dr. William R. Hurst, a family physician from Jonesboro, has been named a diplomat of the American Board of Family Practice.

Dr. Horace Johnson, a general surgeon from Pine Bluff, has been elected secretary of the Southeast Arkansas Medical, Dental and Pharmaceutical Association.

Dr. William N. Jones, a Little Rock dermatologist, recently received the Arkansas Hospital Association's 1992 Distinguished Service Award. Dr. Jones was recognized for his work with the Coalition for a Healthier Arkansas (CHAR) and for his leadership in AIDS awareness.

Dr. Nicholas F. Lang, a general surgeon from Little Rock, has been elected president of the Arkansas chapter of the American College of Surgeons.

Dr. James J. Pappas, an otologist from Little Rock, was recently elected as president of the Otosclerosis Study Group for 1992-1993 at the organization's annual meeting in Washington D.C. For over 50 years, this national organization of otologists from around the country has dedicated itself to improving treatment available for otosclerosis and to furthering research into the causes of this disease.

Dr. Stephen M. Schexnayder, a Little Rock pediatrician, was recently elected to fellowship in the American Academy of Pediatrics.

Dr. Joe Verser, a family physician from Harrisburg, has been named a fellow of the American Academy of Family Physicians. Dr. Verser is the former secretary of the Arkansas State Medical Board.

Dr. Harry Ward, a Little Rock internist, has been named chairman-elect of the Board of Directors of the Association of Academic Health Centers. Dr. Ward is the chancellor of the University of Arkansas for Medical Sciences and a professor of medicine at UAMS.

Dr. James R. Weber, a family physician from Jacksonville, has been elected chairman of the board of directors of the American Academy of Family Physicians. Dr. Weber is an assistant clinical professor in the department of family and community medicine at UAMS.

Dr. Paul Wills, an otolaryngologist from Fort Smith, recently received a special recognition award from the American Academy of Otolaryngology-Head and Neck Surgery for his contributions as chairman of the Board of Governors for 1992. Dr. Wills is currently president of the Sebastian County Medical Society.

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Medicine in the News

Health Care Access Foundation Update

As of November 1, 1992, the Arkansas Health Care Access Foundation has provided free medical service to 4,891 medically indigent persons, received 10,247 applications, and enrolled 21,260 persons.

The program has 1,496 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

AMA Vows to Work with President-elect Clinton for Reform

The AMA sent its congratulations to President-elect Bill Clinton and pledged to work to improve the nation's health system. Raymond Scalettar, M.D., AMA board chair, said:

"The physicians of the American Medical Association are looking forward to working closely with the Clinton Administration to fashion the finest health care system for all Americans.

"American voters clearly want a reformed health system providing quality, cost-efficient health care, while preserving the American tradition of freedom of choice. The mandate provided by the people requires all of us to build on areas of consensus and work through our differences for the sake of our patients.

"America leads the world in health care technology, quality and expertise. Our goal must be to ensure access for everyone while controlling costs as soon as feasible."

McGehee Desha County Hospital Receives National Health Care Grant

A three-year Rural Health Care Transition Grant for $146,516 was recently awarded to McGehee Desha County Hospital. Submitted through the Rural Hospital Program at the University of Arkansas for Medical Sciences, this grant was one of 163 awarded nationally by the Health Care Financing Administration.

McGehee Desha County Hospital will use the money for a "Rural Specialty Consultation Outreach Program." This program will be a joint venture with the UAMS physicians who will provide the citizens of Desha, Chicot and Drew counties with easy access to cost-effective speciality clinics. The Mississippi River Delta Region is an extremely rural and economically disadvantaged area in Arkansas where easy access to affordable health care is needed.

Rural outreach clinics will provide patient access to high level speciality consultations avoiding the hardship, expense and delays associated with long-distance travel. They will replace episodic consultative intervention with continuous medical support and care to lessen the crisis-oriented nature of medical care delivery in the area.

Initially, each outreach specialty clinic will be available a minimum of two days a month in areas such as pediatrics, cardiology, oncology, pulmonology, hematology and high-risk obstetrics according to demand.

In addition, it will provide a specialty teaching base for medical residents in various specialties and quality training programs in a rural practice setting, potentially resulting in more appropriately trained physicians locating in the Delta region, that the University system is reaching out to rural communities in an attempt to help improve their quality of life in a cooperative way.

The proximity of the specialist is expected to greatly improve communication and interaction between the local primary care physician and the consultant; relations between rural hospitals and UAMS; the education and treatment skills of the local physicians, and ultimately, patient care.

UAMS Opens New Kidney Center

The UAMS Medical Center officially opened a new kidney treatment facility recently in the Freeway Medical Center. The center was moved from University Hospital to make access easier for the patients and to provide more space for a growing program.

The center features eight exam rooms, a two-station training center for peritoneal home dialysis training and a 10-station, out-patient hemodialysis unit.

The center offers a very individualized and interdisciplinary approach to dialysis treatment. Patients have the same social worker, account representative and nurse throughout treatment at the center. And, nurses are on-call and available 24 hours for the patients.

Currently, research is being conducted at the center using hypertensive drugs and state-of-the-art peritoneal dialysis cyclers.

In addition to offering dialysis and renal care, the center will soon offer treatment for hypertension and lupus.

Major Agreement Reached on Breast-Conserving Treatment

For the first time, three major health organizations whose members are directly involved in the care of breast cancer patients have agreed on which patients could be offered breast-conservation treatment.

The American College of Surgeons, the American College of Radiology, and the American Cancer Society have developed standards that clarify which patients should be offered lumpectomy and radiation therapy. The College of American Pathologist's Committee on Cancer was also involved in the development of the standards.

The standards state that women whose early breast cancer was picked up by mammography are candidates for the breast-saving treatment. Women with a small lump whose cancer has not spread to surrounding tissues also are candidates. In addition, depending on the size of the tumor in relation to the size of the breast, women whose tumors may have spread also may be candidates.

The standards were developed after considerable discussion and extensive review of major studies. These studies show that the survival rate for many breast cancer patients is the same whether they are treated by mastectomy or lumpectomy and radiation therapy.

"ON THE RIGHT TRACK"

Arkansas Medical Society
117th Annual Session

Arlington Hotel
Hot Springs, Arkansas
April 15 - 17, 1993

Resolution

Robert F. Shannon, M.D.

Whereas, the recent death of one of our most respected colleagues, Robert F. Shannon, M.D., has deeply grieved the members of this Society; and

Whereas, Dr. Shannon was a loyal member of this organization for over 30 years and held numerous leadership positions, including service as a member of the Executive Committee, a Councilor to the Arkansas Medical Society, and as President in 1988; and

Whereas, his pioneering work in psychiatry and his devoted service to the citizens of Arkansas as State Commissioner of Mental Health will be long remembered;

RESOLVED, that this resolution be adopted and stored in the permanent records of this Society; and

RESOLVED, that a copy be sent to Dr. Shannon's family as a token of our sincere sympathy; and

RESOLVED, that a copy be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
October 21, 1992

By Order of the Memorials Committee
Bruce E. Schratz, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

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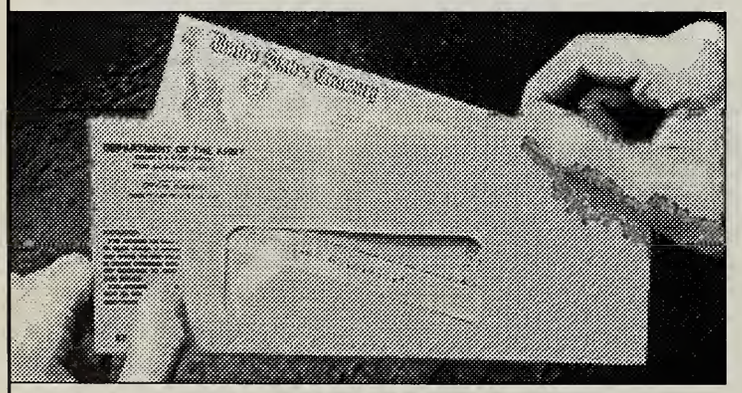

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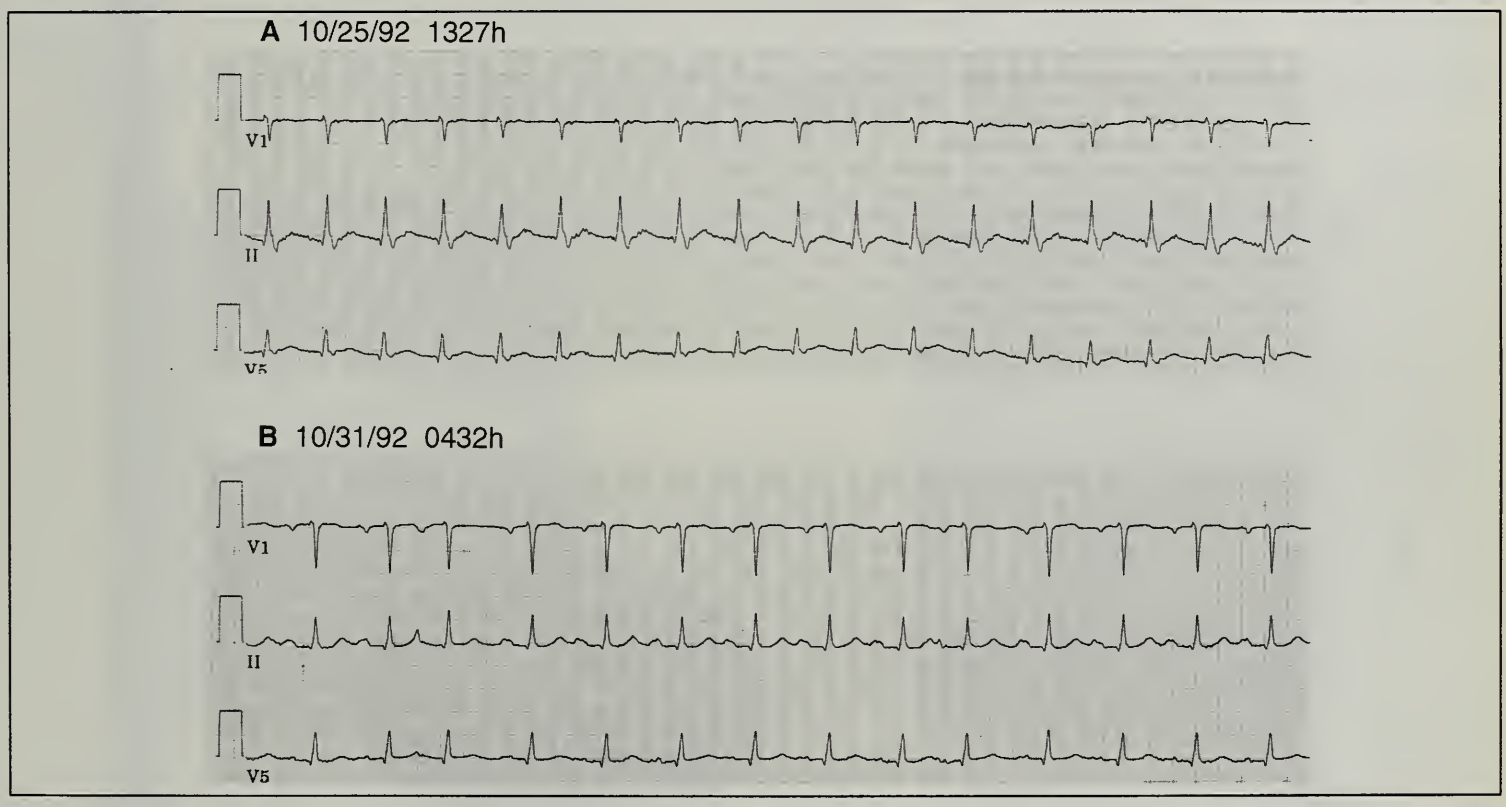
Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

These records were obtained from a 87-year-old man with aortic stenosis. The ECG computer interpreted the rhythm in panel A as a wide QRS tachycardia. What is your diagnosis?



DISCUSSION:

Panel A shows a regular rhythm at a rate of 115 bpm. In panel B, sinus rhythm is present with first degree AV block and frequent premature atrial complexes. On superficial inspection of panel A, there are no P waves evident. The QRS duration in panel A is 140 ms versus 100 ms in panel B. The morphology of the initial 80 ms of the QRS complex is identical to that observed in panel B. What appears to be a terminal S wave in lead II (as well as in III and aVF) is in fact a retrograde P wave. This morphology results from activation of the atria from the AV node. The presence of retrograde P waves with otherwise normal QRS morphology indicates that the rhythm is a junctional tachycardia, rather than a wide QRS tachycardia. This morphology in the inferior leads may easily be confused with right bundle block (RBBB). However, RBBB usually results in broad S waves in the inferior leads and an rSr' morphology in V1. Although a small r' is evident in V1, it is much later than would be expected in RBBB.

The rate between 70 and 130 bpm suggests that this is a non-paroxysmal junctional tachycardia (NPJT). Non-paroxysmal junctional tachycardias are due to enhanced automaticity of the AV node and are characterized by gradual onset and reversal and slower rates. By contrast, proxysmal junctional tachycardias which are due to AV nodal reentry (now termed AV nodal reentrant tachycardia or AVNRT) are associated with abrupt onset and termination and rates in the range of 150-250 bpm. NPJT occurs most commonly in patients with underlying myocardial disease including inferior myocardial infarction, myocarditis, or after open-heart surgery. NPJT may also be an important manifestation of digitalis excess, particularly when accompanied by evidence of exit block. NPJT is generally well tolerated clinically with treatment being directed at the underlying disorder.

MODULATE/DEMODULATE MODEM ETHERNET SINGLE USER
EGA CLEARING HOUSE BI-SYNCHRONIS
PC-XT/AT XENIX
CGA ELECTRONIC CLAIMS SUBMISSION
MEGAHERTZ RAM REMOTE ACCESS VGA UNIX
ASYCHRONIS MEGABYTES ROM ARCNET
SERIAL PORTS MIPS
HIGH DENSITY
TACTLE HARD DISK
WORKSTATIONS VGA
9 PIN DOT MATRIX DATA TRANSFER
UNATTENDED POLING CPS
BARCODE RE
DOS PARALELL INTERFACE
MAGNETIC MEDIA MGA
MONOGRAPHIC ADAPTER
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AT COMPATIBLE BAUD RATE
WORM DRIVE A-B SWITCH
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NETWORKING
ACCEPT ASSIGNMEN
CROSSOVER CLAIM EDS
CHARGE SLIPS HMO WRITE-OFF
CURRENT PROCEDURAL TERMINOLOGY
OUTSIDE LAB CHARGES
SUPERBILL PPO
WORKMAN'S COMP
ICD DIAGNOSIS CODES
REFERRING PHYSICIAN SECONDARY
GROUP NUMBER HICFA
PLACE OF SERVICE CODE
PRIMARY CARRIER
PRIOR AUTHORIZATION
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DATE OF DISABILITY
SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO
RESPONSIBLE PARTY
DATE OF ACCIDENT PATIENT RECORDS INDIVIDUAL POLICY NUMBER

Radiological Case of the Month

Steven R. Nokes, M.D.
Paul K. Osteen, M.D.
Robert L. Fincher, M.D.

History:

This 29-year-old woman presented with two palpable right breast lesions. A mammogram and ultrasound were obtained.

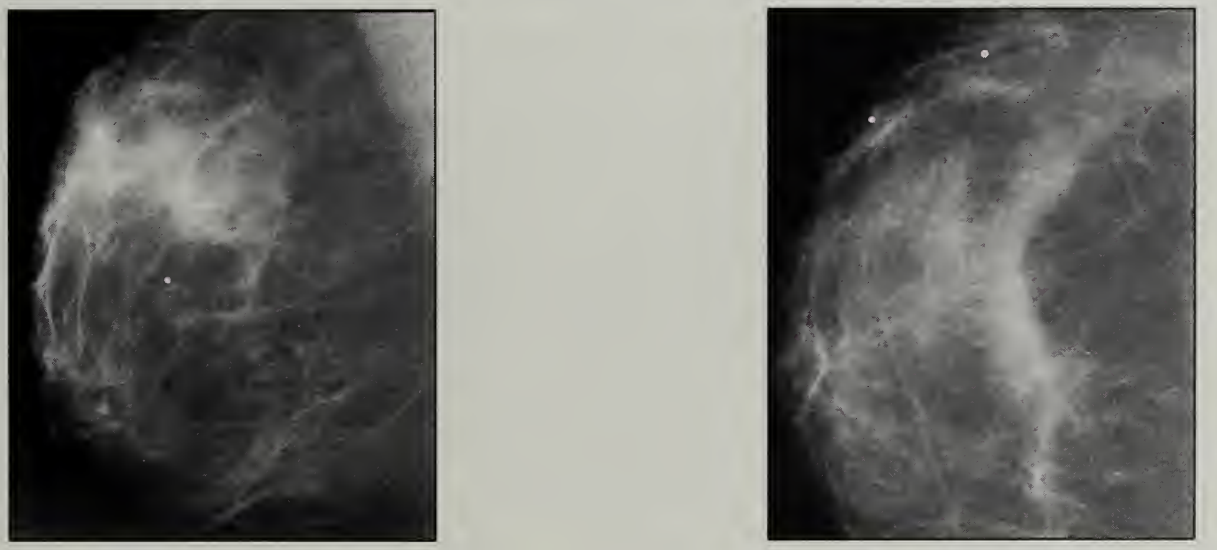


Figure 1a and b. Mediolateral oblique and craniocaudal film screen mammograms of the right breast. The masses are marked with lead.

Figure 2. Cone down mediolateral oblique view of the superior lesion.

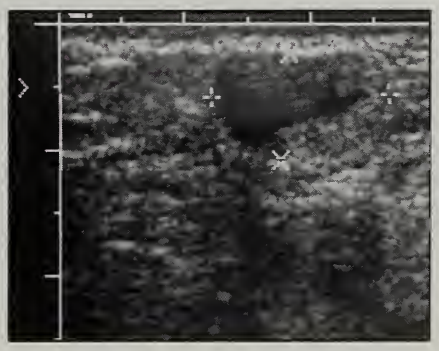


Figure 3. Ultrasound of the superior right breast mass.

Galactocele

Findings:

The radiographic markers overlie two approximately one centimeter well-circumscribed lesions in the right breast (figures 1a and b). The cone down view reveals a fat-fluid level, with radiolucent fat superior (arrows). The ultrasound confirms a fluid level with echogenic fat layering superior to fluid. The fluid level is not demonstrable on the craniocaudad view.

Discussion:

A galactocele is benign breast lesion that contains milk. This usually occurs in young women, during lactation, although it has been described in men and children. The clinical presentation is that of single or multiple nodules. It can be discovered during screening mammography.

Three radiographic patterns are described. The most characteristic is that of a fat-fluid level seen on an upright film (mediolateral oblique), as seen in our patient. The fat and water densities may be mixed, in which case a galactocele cannot be differentiated from a hamartoma, but both are benign. Lastly, a galactocele may appear as a nodule of uniform density and be indistinguishable from neoplasm. The ultrasound findings have not been described, but correspond to the mammographic appearance.

Aspiration is diagnostic, revealing white fluid of variable viscosity. Biochemical analysis is unnecessary, but reveals varying proportions of proteins, fat and lactose.

We would like to thank Marjorie Hammons for preparing the manuscript.

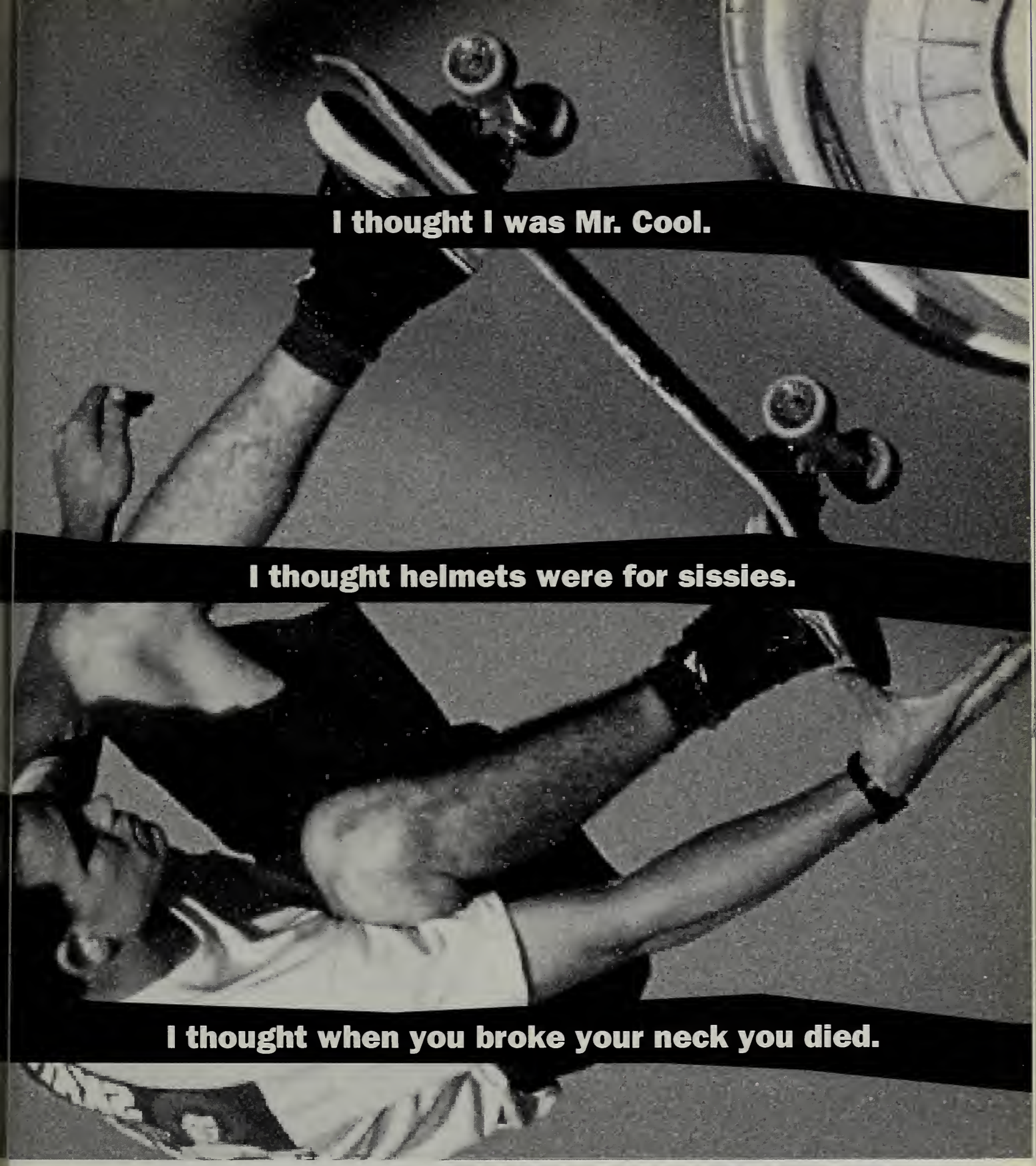
References

Gomez A, Mata JM, Donoso L, Rams A. Galactocele: Three distinctive radiographic appearances. Radiology, 1986;158:43-44.

Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.

Contributor: Paul K. Osteen, M.D., is affiliated with the Surgical Clinic in Little Rock.

Contributor: Robert L. Fincher, M.D. is affiliated with Radiology Consultants in Little Rock.



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Things To Come

January 8-9, 1993

15th Annual What's New in General Surgery. Hyatt Regency, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. Fees: $285, physicians; $200, others. For more information, call (916) 734-5390.

January 17-19

Ambulatory Gynecology. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

January 24-30

19th Annual Midwinter Program for Physicians. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

February 5-6

11th Annual Infectious Disease Conference. Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

February 21-26

Emergency Medicine. Hyatt Regency, Incline Village (North Lake Tahoe), NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. Fees: $425/$325, past participant; $465/365, non-past participant. CME accreditation offered. For more information, call (916) 734-5390.

March 6-11

20th Annual Critical Care Medicine Course. Oklahoma City Marriott Hotel. Sponsored by the Department of Medicine, College of Medicine, The University of Oklahoma Health Sciences Center and the Veterans Affairs Medical Center in conjunction with the Office of Continuing Medical Education. Fees: $650. CME accreditation offered. For more information, contact Dora Lee Smith at (405) 271-5904.

March 8-12

Radiation Safety Specialist Training Program. Oklahoma City, OK. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

March 10-13

Health Care '93. Sunshine City Exhibition Center, Ikeburuko, Tokyo. Sponsored by JETRO (Japan External Trade Organization). For more information, call JETRO-Houston (713) 759-9595.

March 13

Women's Health and Breast Cancer. University of California, Davis, Medical Center, Cancer Center Auditorium, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the UC, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

March 18-20

Spring Break for CME. PGA National Resort & Spa, Palm Beach Gardens, FL. Sponsored by the Florida Medical Association. CME accreditation offered. Fees: $385. For more information, call (904) 356-1571.

March 25-27

Laboratory Workshop in Breast Reconstruction. Sentara Norfolk General Hospital, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 2-3

Ambulatory Pediatrics. Sacramento Inn, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

April 8-9

Hands-On Workshop on Advanced Diagnostic Methods in Andrology. Jones Institute of Reproductive Medicine, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 16-18

43rd Annual Postgraduate Symposium on Anesthesiology. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the Department of Anesthesiology, the University of Kansas Medical Center. CME accreditation offered. For more information, call (913) 588-4488.

April 18-20

13th Annual Meeting of the American Society for Laser Medicine and Surgery. Marriott Hotel, New Orleans, LA. CME accreditation offered. For more information, call (715) 845-9283.

April 23

Thrombolysis: It's Role in Peripheral, Arterial and Venous Disorders. Omni International Hotel, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 23-24

5th Annual Pediatrics & All That Jazz: Current Practice and Recent Advances. Brent House Hotel, New Orleans, LA. Sponsored by the Alton Ochsner Medical Foundation, New Orleans. For more information, call (504) 842-3702.

April 26-30

Radiation Safety Instrumentation & Compliance. Sheraton Plaza Hotel, Orlando, FL. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

April 29-May 2

Clinical Electrocardiography: Basic Concepts & Interpretation - 13th Edition. Ritz-Carlton Hotel, Philadelphia, PA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

May 6-9

Practical Dermatology for the Primary Care Physician - 19th Edition. Ritz-Carlton Hotel, Pentagon City, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

June 3-5

3rd International Biological Effects of Light Symposium. Wenkenhof Riehen meeting Center, Basel, Switzerland. Sponsored by the Light Symposium Foundation. For more information, call Scott B. Watt at (404) 432-2409.

June 6-11

9th Annual EVMS Family Medicine Review Course. The Cavalier Hotel, Virginia Beach, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

June 25-27

11th Summer Symposium in Internal Medicine. Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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Family Medicine Spring Academic Conference

May 21-23, 1993, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

Arkansas Medical Society 117th Annual Session

April 15-17, 1993, The Arlington Hotel, Hot Springs. Registration information will be forthcoming. For more information, contact Kay Waldo at (501) 224-8967 or 1-800-542-1058.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, November 13 & December 11, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, VAMC auditorium

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Sleep Disorders Case Conference, 1st & 3rd Thursday, 12:00 noon, Sleep Disorders Center conference room. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Category 1 credits available. Lunch provided
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2

Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Pediatric Advanced Life Support Course, December 11-12, AHEC
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center

Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Arkansas Medical Society Membership Roster as of November 10, 1992

 # Denotes deceased member

Arkansas County
Burleson, Stan W.
Daniel, Noble B. III
Guyer, G. L.
Hestir, John M.
John, Milton C. Jr.
Millar, Paul H. Jr.
Morgan, Jerry D.
Northcutt, Carl E.
Pritchard, Jack L.
Speer, Hoy B. Jr.
Speer, Marolyn N.
Wilson, Richard
Yelvington, Dennis B.

Ashley County
Beauchamp, Kermen D.
Burt, Frederick N.
Garcia, Luis F.
Gresham, Edward A.
Grigsby, Benson
Heder, Guy W.
Holt, Terry
Rankin, James D.
Ripley, Curtis E.
Salb, Robert L.
Thompson, Barry V.
Toon, D. L.
Walsh, Benjamin J.

Baxter County
Adkins, Kevin J.
Baker, Robert
Barker, Monty
Chatman, Ira D.
Cheney, Maxwell G.
Chock, Daniel P.
Chock, Helga E.
Clarke, James S.
Condrey, Yoland M.
Cook, James T.
Douglas, Donald S.
Dyer, William
Dykstra, Peter C.
Elders, John Gregory
Ford, William
Guenthner, John F.
Hardin, Philip R.
Hollis, Roland
Johnson, Stacey M.
Kelley, Lawrence A.
Kerr, Robert L.
Kilgore, Kenneth M.
Knox, Thomas E.
Landrum, William
Lincoln, Lance
MacKercher, Peter A.
Massey, James Y.
Neis, Paul R.
Regnier, George G.
Rigler, Wilson F.
Robbins, Robert H.
Roberts, David H.
Saltzman, Ben N.
Sneed, John W. Jr.
Stahl, Ray E. Jr.
Sward, David T.
TerKeurst, John
Trager, Marc
Tullis, Joe M.
Turner, Frederick C.
Webb, E. Russell
Wells, Gary
White, Richard
Wilbur, Paul F.
Wilson, Jack C.
Yoder, Robert Raymond

Benton County
Addington, Alfred R.
Adrian, James A.
Allen, L. Barry
Allen, William M.
Arkins, James
Atkinson, Thomas
Ball, Eugene H.
Becton, Paul Jr.
Benjamin, George
Bledsoe, James H.
Boden, Donna
Boozman, Fay W. III
Clemens, R. Dale
Clower, John D.
Cohagan, Donald L.
Cole, Randall E.
Compton, Neil E.
Costaldi, Mario E.
Dang, Minh-Tam
Day, Geoffrey
Diacon, W. Lindley
Donnell, Hugh Garland
Donnell, Robert W.
Drange, R. Kirk #
Duensing, Theodore
Elkins, James P.
Ewart, David
Fioravanti, Bernard L.
Garrett, David C. III
Goss, Stephen
Hales, David
Harmon, Harry M.
Henderson, Oscar L.
Hitt, Jerry L.
Hof, C. William
Holder, Robert E.
Horner, Glennon A.
Howard, K. Lamar
Hull, Robert R.
Huskins, James D.
Huskins, John A.
Jacks, John W.
Jennings, William E.
Johnson, Christopher S.
Keane, Patrick K.
Knapp, James R.
Martin, Albert Jr. #
McCollum, Edward
McCollum, William
McKnight, William D.
Mertz, John Douglas
Moose, John I.
Motta, Paul
Mulchin, Walter
Mullins, Neil D.
Neaville, Gary A.
Panettiere, Frank J.
Pappas, John J.
Pearson, Richard N.
Pickens, James L.
Platt, Michael R.
Poemoceah, Kenneth M.
Puckett, Billy J.
Reese, Michael C.
Revard, Ronald
Ritz, Ralph C.
Rodgers, Harold
Rollow, John A.
Rolniak, Wallace A.
Springer, Dan J.
Steadman, Hunter M. Jr.
Stinnett, Charles H.
Stinnett, Scott G.
Stolzy, Sandra
Summerlin, William
Swaim, Terry J.
Swindell, William G.
Treptow, Douglas
Turley, Jan T.
Ubben, Kenneth
Waldon, Gene B.
Warren, Grier D.
Weaver, Donald D.
Weaver, Robert H.
Wilkerson, Danny
Wright, Larry D.
Wulz, Curtis
Youngblood, Thomas

Boone County
Ashe, Barbara
Ashford, Walter P.
Bell, Thomas Edward
Bennett, Joe D.
Brandon, Henry
Casey, Rick E.
Chambers, Carlton L. III
Crider, James T.
Daniel, Charles D.
Dunaway, Geoffrey
Ferguson, Noel F.
Fowler, Ross E.
Garland, William J. Jr.
Gladden, Jean C.
Hoberock, Thomas R.
Hutcheson, Galen
Jennings, Larry B.
Kim, Hyewon
Kirby, Henry V.
Klepper, Charles R.
Langston, Robert H.
Langston, Thomas
Laule, Alice R.
Ledbetter, Charles A.
Mahoney, Paul L. Jr.
Miller, Robert Jr.
Padilla, Jose S.
Rozeboom, Victor A.
Scroggins, Sam J.
Simpson, Thomas J. #
Smith, H. Van
Troupe, John T.
Vowell, Don R.
Williams, Rhys A.

Bradley County
Chambers, F. David
Coyle, Pamela
Marsh, James W.
Pennington, Kerry F.
Schultz, Wayne H.
Wharton, Joe H.
Wynne, George F.

Carroll County
Card, Shannon R.
Flake, William K.
Horton, Charles
Kresse, Gregory
Martinson, Alice
Spurgin, Randal Truman
Stensby, Harold F.
Taylor, Richard L.
Wallace, Oliver

Chicot County
Burge, John P.
DeRamos, Agapito Y.
Jackson, John III
Kronfol, Ned
Russell, John R.
Smith, Major E.
Thomas, H. W.

Tuangsithtanon, T.
Tvedten, Tom
Weaver, William J.
Wilson, Thomas C.

Clark County
Anderson, P. R.
Balay, John W.
Ford, Michael Ray
Hagood, Noland Jr.
Lowry, James
Parsons, V. Earl Jr. #
Peeples, George R.
Studdard, Daniel
Taylor, George D.
Toombs, Vernon L.

Cleburne County
Baldridge, Max
Barnett, James C.
Barnett, Michael
Beasley, Harold
Campos, Amador
Ewing, Jon R.
Ferguson, John
Lambert, James C.
Murry, J. Warren
Poff, Joseph H.
Poff, Nathan L.
Smith, James F.
Thomas, Jerry L.
Vaughan, G. Lee

Columbia County
Alexander, John E. Sr.
Alexander, John E. Jr.
Baldwin, Ronald L.
Evans, Matthew L.
Farmer, John M.
Griffin, Rodney L.
Hester, Joe D.
Hunter, Robert W. Jr.
Kelley, Charles W.
McMahen, H. Scott
Murphy, Fred Y.
Parkman, Robert L. Jr.
Pullig, Thomas A.
Roberts, Franklin D.
Ruff, John L.
Strange, Vance M.
Walker, Jack T.
Weber, Charles

Conway County
Hickey, Thomas H.
Lipsmeyer, Keith M.
Lyon, Jack
Owens, Gastor B.
Rozzell, Allen R.
Wells, Charles F.

Craighead-Poinsett County
Alston, Herman D.
Aston, J. Kenneth
Austin, Lester K. Jr.
Ball, John
Barker, Charles
Bartlett, Sylvan
Basinger, James W.
Beck, M. Lowery
Berry, Donald M.
Blachly, Ronald J.
Blaylock, Jerry D.
Bodeker, Larry J.
Boyd, John T.
Braden, Terence P. III
Brown, Dennis R.
Brown, Mark C.
Buckner, John H.
Burns, Richard G.
Burns, Robert
Camp, Michael
Carpenter, Kennan
Clopton, Owen H. Jr.
Cohen, Robert S.
Cook, John
Cranfill, Ben
Cranfill, General L. III.
Crawley, Michael E.
Degges, Russell D.
Dickson, Glenn E.
Dunn, Charles C.
Eddington, William R.
Edgerton, Ada
Emerson, Steven
Fairleigh, David E.
Felts, Larry S.
Fields, L. Brad
Forestiere, A. J.
Fowler, William
Garner, William L.
George, F. Joseph
Golden, Stephen C.
Gossett, Clarence E.
Goza, Gary R.
Green, William
Guinn, Donald R.
Hall, Ray H. Jr.
Hiers, Connie L.
Hightower, Michael D.
Hill, Roger D.
Hogue, Ernest L.
Hoke, W. Scott
Hubbard, William S.
Hurst, William
Isaacson, Michael L.
James, Frank M.
Jennings, R. Duke
Jiu, John B.
Johnson, Larry H.
Johnson, Roehl W.
Jones, K. Bruce
Jones, R. J.
Jordan, Harry J. #
Keisker, Henry W.
Kemp, Charles E.
Kroe, Donald J.
LaCour, Edmund
Landry, Robert J.
Lassonde, Robert G.
Lawrence, Robert O. Jr.
LeNarz, LeRoy A.
Ledbetter, Joseph W.
Lepore, Diane G.
Levinson, Mark
Lewis, David M.
Lunde, Stephen P.
Luter, Dennis W.
Mackey, Michael
Maglothin, Douglas L.
Mahon, Larry E.
Marzewski, David
McDaniel, Craig A.
Mitchell, George E. #
Modelevsky, Aaron C.
Montgomery, Earl W.
Moore, Steven M.
Moseley, Claiborne II.
Nash, Jerry
Nixon, D. Allen Jr.
Owens, Ben Jr.
Peacock, Loverd
Peeler, Malcolm O. #
Porter, Revel D.
Pothuloori, Manmohan P.
Price, Edwin F.
Price, Herbert H. III
Price, Joel A.
Pyle, David
Ragland, Darrell G.
Rainwater, W. T.
Raney, Bascom P. #
Ricca, Dallie
Ricca, Gregory F.
Robbins, Robert A.
Roberts, Randy D.
Rogers, James F.
Rusher, Albert H. Jr.
Ryals, Rickey O.
Sanders, James W.
Sapiro, Gary S.
Saunders, Earnest
Savage, Patrick Joseph
Schrantz, James L.
Schweitzer, Terri
Scriber, Ladd J.
Scroggin, Carroll D. Jr.
Shanlever, Rufus C.
Shanlever, William T.
Sifford, Mark
Silas, David
Skaug, Phyllis
Skaug, Warren A.
Smith, Floyd A. Jr.
Smith, Vestal B.
Sparks, Barrett
St Clair, John T. Jr.
Stainton, Joseph C.
Stainton, Robert M. Jr.
Stallings, Joe H. Jr.
Stank, Thomas M.
Stevenson, Richard
Stilson, Rebecca
Stripling, Mark C.
Stubblefield, Sandra
Suprock, Mark
Swingle, Charles G.
Taylor, Robert D.
Tedder, Barry C.
Tedder, Michael E.
Teply, Joseph F.
Thomas, Gary A.
Tidwell, Kenneth Jr.
Tonymon, Kenneth
Tuck, Rebecca
Utley, Phillip M.
Verser, Joe
Vines, Troy Alan
Vollman, Don B. Jr.
Walker, Meredith M.
Warner, Robert L. Jr.
Webb, James W.
White, Anthony T.
Wiggins, H. Lynn
Williams, E. Walden
Wilson, Joe T. Jr.
Wisdom, Garland D.
Woloszyn, John
Woodruff, Stephen O.
Woodward, Gary W.
Yates, Robert L.
Young, Richard S.
Young, S. Morris #
Young, William C. Jr.

Crawford County
Darden, Lester R.
Delk, John II
Edds, Millard C.
Edwards, Henry N.
Floyd, Rebecca
Harford, Martin
Hefner, David P.
Jennings, Charles A.
Kale, Robert
Ross, R. Wendell
Sasser, L. Gordon III
Schlabach, Ronald D.
Shearer, Francis E.
Sills, D. Bart
Travis, A. Lawrence

Crittenden County
Adler, Justin Jr.
Arnold, Sidney W.
Bryant, G. Edward Jr.
Clemons, Mark
Deneke, Milton D.
Evans, Loraine J.
Ferguson, Scott
Ferguson, T. Murray
Ford, Robert C. Jr.
Hamilton, Ralph B. #
Hernandez, Jacinto
Herrington, C. G. Cap Jr.
Hodges, John M.
Huffstutter, Paul J.
Jay, Gilbert D. III
Kennedy, Keith B.
Khan, Mohammed B.
L'Heureux, Guy J.
Lubin, Milton
McCalla, Mary
Meredith, Samuel G. Jr.
Miller, James L.
Nadeau, Kenneth R.
Peeples, Chester W. Jr.
Pierce, Trent P.
Schoettle, Glenn P.
Schoettle, Steve P.
Shrader, Floyd R.

Smith, Bedford W.
Utley, L. Thomas
Wah, John
Webb, Dan W.
Westbrook, H. Wade
Wright, William J.

Cross County
Beaton, James
Beaton, Kenneth E.
Bethell, Robert D.
Burks, Willard G.
Crain, Vance J.
Hayes, Robert A. Jr.
Roberson, Charles

Dallas County
Davis, Paul
Delamore, John H.
Dobson, Jack T. #
Howard, Don
Moran, Paul
Nutt, Hugh A.

Desha County
Go, Peter Kong Hua
Harris, Howard R.
Hoagland, Robert A.
Masquil, Filipe
Robinson, Guy U.
Turney, Lonnie R.

Drew County
Burns, Robert E.
Busby, Arlee K.
Maxwell, Ralph M.
McKiever, William R.
Wallick, Paul A.
Williams, William III
Wilson, Harold F.

Faulkner County
Archer, Charles A. Jr.
Beasley, Margaret D.
Benafield, Robert B.
Bowlin, Randal
Daniel, Sam V.
Furlow, William C.
Garrison, James S.
Ghormley, Jonathan
Gordy, L. Fred Jr.
Hendrickson, Richard Jr.
Hilman, Michael G.
Holland, Rhonda
Jackson, Carole
Jones, Shelly
Landberg, Karl H.
Magie, Jimmie J.
Martin, David A.
Marvin, Peter
McCarron, Robert
McChristian, Paul L.
Murphy, Kenneth
Pullman, Norman
Shirley, David C.
Smith, John D.
Smith, Lander A.
Stancil, Vicki
Stone, Phillip
Throneberry, Bart
Wilson, Paul H.

Franklin County
Gibbons, David L.
Long, C. C.
Smith, John C.
Wilson, Robert

Garland County
Arthur, James M.
Aspell, Robert
Astle, Nancy
Atherton, Lee G.
Atkinson, Robert H. #
Bandy, Preston R.
Beamer, Lee F.
Bodemann, Diane
Bodemann, Michael C.
Bodemann, Stephen L.
Bohnen, Loren O.
Borg, Robert V.
Bracken, Ronald J.
Braley, Richard E.
Braun, James R.
Brunner, John H.
Bumpas, Timothy F.
Burton, Frank M.
Burton, James F.
Campbell, James W.
Cates, Jack A.
Chamberlain, Joe W. #
Chu, Thomas
Cunningham, Mark
Cupp, Cecil W. III
Davis, Sheryl L.
Dembinski, T. Henry
Dodson, John W. Jr.
Dolan, Patrick III
Dunn, Richard W.
Durham, Thomas M. Jr. #
Eisele, W. Martin
English, P. Timothy
Finan, E. Michael
Fine, B.D. Jr.
Fore, Robert W.
Fotioo, George J.
French, James H.
Gardial, J. Richard
Gardner, James L.
Gocio, Allan C.
Griffin, James E.
Haggard, John L.
Hale, Kevin D.
Hansen, Dana
Harper, Edwin L.
Headrick, Daniel
Hechanova, D. M. Jr.
Heinemann, Fred M.
Hill, Robert L.
Hollis, Thomas H.
Howe, H. Joe
Humphreys, Robert P.
Irwin, William G.
Jackson, Haynes G.
James, Janeen
Jayaraman, K. K.
Jayaraman, Vilasini D.
Jayasundera, Naomal S.
Johnson, Paulette S.
Johnson, Robert D.
Johnston, Gaither C.
Kaler, Ron A.
Keadle, William R.
Kincheloe, A. Dale
King, Leeman H.
Kleinhenz, Robert W.
Klugh, Walter G. Jr.
Koehn, Martin A.
Lane, Charles S. III
Lang, Patricia A.
Larrison, Charles A.
Lee, William R.
Lovell, Clawrence R.
Martin, Jana
Maruthur, Gopakumar
Mashburn, William R.
McConkie, Stuart
McCrary, Robert F. Jr.
McFarland, Louis R.
McMahan, James
Meek, Gary N.
Munos, Louis R.
Newton, Doane M. #
Olive, Robert Jr.
Pai, Balakrishna
Pappas, Deno P.
Parkerson, Cecil W.
Peeples, Raymond E.
Pellegrino, Richard
Powell, Brenda
Queen, George P.
Rainwater, W. Sloan
Reddy, Prabhakara K.
Robert, Jon M.
Rosenzweig, Joseph L.
Russell, Mark
Sanders, Hallman E.
Schmidt, Clinton C.
Seifert, Kenneth A.
Shroff, Rajesh K.
Simpson, John B.
Slaton, Catherine R.
Slaton, G. Don
Slezak, James
Smith, Bruce L. Jr.
Smith, John
Smith, Phillip L.
Sorrels, John W.
Springer, Melvin R. Jr.
Springer, William Y.
Stecker, Elton H. Jr.
Stecker, Rheeta M.
Stough, Dowling Bluford III
Thomas, W. Al
Thompson, Thomas P. Jr.
Trieschmann, John W.
Tucker, R. Paul
Wallace, Thomas
Walley, Luther R.
Webb, Timothy
Woodward, Philip A.
Wright, Charles C.

Grant County
Irvin, Jack M.
Paulk, Clyde D.

Greene-Clay County
Baker, A. J.
Baker, Clark M.
Boggs, Dwight F.
Bonner, J. Darrell
Brown, Peggy
Cagle, Roger E.
Collier, George H. Jr.
Crow, Asa A.
Duckworth, Hillard R.
Fonticiella, Adalberto
Hardcastle, R. Lowell
Harper, Bland
Hazzard, Marion P.
Hobby, George A.
Jackson, Ron
Kemp, Clarence
Lawson, J. Larry
Martin, Richard O.
Mitchell, Bennie E.
Morrison, Jimmy
Muse, Jerry L.
Page, Billie C.
Purcell, Donald I.
Rollins, William
Sellars, John R.
Shedd, Leonus L.
Sheridan, James G.
Shotts, C. Mack Jr.
Shotts, Vern Ann
Smith, Norman
Watson, Samuel D.
White, Robert B.
Williams, Dwight M.
Williams, Jacob M.

Hempstead County
Cardwell, Daniel
Harris, Lowell O.
Holt, Forney G.
McKenzie, Jim
Portis, Richard P.
Stevens, David G.
Wright, George H.

Hot Spring County
Bollen, A. Ray
Brashears, Larry B.
Burton, Bruce K.
Cobb, Russell W.
Ellis, C. Randolph
Highsmith, Vivian F.
Kersh, N. B.
Loyd, Gregory M.
Peters, Claude F.
Tilley, Absalom
Vaughan, John A.
White, Bruce A.
White, Robert H.

Howard-Pike County
Dunn, Robert
Floyd, Mark A.
Gullett, A. Dale

Hopson, Deanna
Humphreys, T. J. Jr.
King, Joe D.
Patel, Madanmohan
Peebles, Samuel W.
Sayre, John
Sykes, Robert
Turbeville, James O.
Ward, Hiram T.
White, Phillip L.

Independence County
Alexander, William Steve
Allen, James D.
Baker, John R.
Baker, Robert V.
Baxley, Paul J.
Beck, Carl T. #
Bess, Lloyd G.
Bowman, Gary
Brown, Hunter Lee
Brown, Verona T.
Burnette, David Sr.
Davidson, Andy
Davidson, Dennis O.
Fulbright, Thomas
Goodin, William H. Jr.
Hays, Sarah F.
Jones, Edward J.
Jones, Edward T.
Kearns, Harry
Ketz, Wesley J.
Lambert, John S.
Lytle, Jim E.
McClain, Charles M. Jr.
Moody, Lackey G.
O'Brien, Marcus D.
Piediscalzi, Nicholas
Raney, W. Troy
Scott, John G.
Sherwood, Gary
Simpson, Ronald
Slaughter, Bob L.
Sloan, Fredric J. II
Smith, Bob G.
Stalker, James M.
Strickland, Nathan E.
Sutterfield, Terry F.
Taylor, Chaney W.
Taylor, Charles A.
Tucker, Charles L.
Waldrip, William J. III
Walton, Robert B.
Webster, Russell P.
Zini, James E.

Jackson County
Ashley, John D. Jr.
Carney, J. W.
Chauhan, Mufiz A.
Cole, B. Eliot
Dudley, Guilford M. III
Falwell, K. Wade
Foote, John W.
Frankum, Jerry M. Jr.
Hergenroeder, Paul J.
Jackson, Jabez Fenton Jr.
Junkin, A. Bruce
Poon, Hon K.
Reynolds, Roland C.
Williams, Thomas E.
Young, Jack S. III

Jefferson County
Anderson, Charles W.
Armstrong, Simmie Jr.
Atiq, Omar
Atkinson, Evangelina
Atkinson, Robbie
Atnip, Gwyn
Attwood, H.
Bell, Carl H. Jr.
Bennett, Keith
Blackwell, Banks
Bracy, Calvin M.
Brooks, R. Teryl Jr.
Bruton, J. Lewis
Buckley, J. Wayne
Burford, Thomas G.
Busby, John
Butler, Robert C.
Campbell, James C. Jr.
Carlton, Irvin L.
Cheek, Ben H.
Clark, Charles A.
Crenshaw, John
Croswell, Kent
Davis, Charles M.
Dedman, John D.
Deneke, William
Duckworth, Thomas S.
Fendley, Ann E.
Fendley, Claude E.
Fendley, Herbert F.
Flowers, Martha A.
Forestiere, Lee A.
Freeman, William H.
Frigon, Gary F.
Frigon, Jacquelyn S.
Glasscock, Robert E.
Green, Horace L.
Gullett, Robert R. Jr.
Hardin, J. David
Harper, William F.
Henderson, Francis M.
Hughes, L. Milton
Hulsey, Matthew
Hussain, Shafqat
Hutchison, E. L.
Hyman, Carl E.
Irwin, Raymond A. Jr.
Jacks, David C.
Jacks, Dennis
James, William J.
Jenkins, Bobby
Jenkins, Mary Ellen
Johnson, Horace
Joseph, Aubrey S.
Justiss, Richard D.
Khan, Mahmood A.
King, Yum Y.
Langston, Lloyd G.
Ligon, Ralph E.
Lim, William N.
Lindsey, James A.
Lum, Don
Lupo, David A.
Lytle, John O.
Mabry, Charles D.
Marcus, Herschel
McDonald, Robert L.
McFarland, Mike S.
Mehta, Shyam P.
Meredith, William R.
Miller, Donald L.
Milligan, Monte C.
Morris, Harold J.
Newan, Michael
Nixon, David T.
Nixon, William R.
Nuckolls, J. William
Pearce, Malcolm B.
Pierce, J. R. Jr.
Pierce, Reid
Pierce, Ruston Y.
Plaza, Jesus' A.
Raney, Oliver C.
Reid, Lloyene B.
Ridling, Anna T.
Roaf, Sterling A.
Roberson, George V. Jr.
Robinette, Joseph S.
Rogers, Henry L.
Ross, Robert L.
Samuel, Ferdinand K.
Shorts, Stephen D.
Simmons, Calvin R.
Simpson, P. B. Jr.
Smith, Paul L.
Stern, Howard S.
Sullenberger, A. G.
Tanner, Ronald D.
Townsend, Thomas E.
Tracy, C. Clyde
Waheed, Atiya N.
Walajahi, Fawad H.
Washington, Erma
Wilkins, Walter J. Jr.
Wineland, Herbert L.
Worrell, Aubrey M. Jr.

Johnson County
Burch, Mary JaNell
McKelvey, Richard
Pennington, Donald H.
Shrigley, Guy P.

Lafayette County
Harbin, Bradley
Hutson, Sanford E. III
Lee, Willie J.

Lawrence County
Hughes, Joe E.
Joseph, Ralph F.
Lancaster, Ted S.
Langley, Michael G.
Quevillon, Robert D.
Spades, Sebastian A. III
Wilson, Stephen K.

Lee County
Balke, Susan W.
Fields, E. C. #
Gray, Dwight W.
Ly, Duong N.

Little River County
Armstrong, James
Dalby, Robert D.
Peacock, Norman W. Jr.
Shelton, Joseph Jr.

Logan County
Alexander, Eugene
Buckley, Douglas A.
Chalfant, Charles
Daniel, William R.
Enns, Wayne P.
Harbison, James D.
Roberts, William J.
Smith, James T.
Ulrich, Guy
Williams, John R.

Lonoke County
Abrams, Joe A.
Anderson, Leslie
Chapman, Jerry C.
Elam, Garrett
Gartman, Joseph F.
Holmes, Byron E.
Inman, Fred C. Jr.
Schumann, Gerald M.
Washburn, C. Yulan #

Miller County
Alkire, Carey
Andrews, A. E. Jr.
Barnes, Walter C. Jr.
Brown, Sam F.
Burroughs, James C.
Collins, Stanley
Cummins, J. Craig
Cutler, Otis
Desrochers, Paul E.
Dildy, Edwin V. Jr.
Ditsch, Craig E.
Dodd, N. Leland
Dodge, John M.
Duncan, Donald L.
Eichler, Edward A. Jr.
Fisher, John
Ford, John Suffern
Fournier, Donald C.
Gabbie, Mark
Gillean, John A.
Graham, John
Green, R. Clark
Hall, Eric E.
Hall, Jon D.
Harrell, William B. Jr.
Harris, C. Lynn
Hillis, Thomas M.
Hodson, Gregory
Hughes, A. Keith
Hutcheson, Fred A. Jr.
Jean, Alan B.
Jones, John W.
Joyce, Frederick E.
Kemp, Karlton H.

Kittrell, James
Knowles, Stanley C.
Leavelle, Ray W. #
Loe, Arlis W.
Mayo, Russell
McGinnis, Robert S. Sr.
Morris, Howard
Newton, Norris L.
Newton, Norris L. Jr.
Northam, Jon Mark
Northam, Wanda M.
Peebles, Larry M.
Robbins, Joseph
Robertson, William
Rountree, Glen A.
Royal, Jack L.
Sarrett, James
Schmidt, Howard
Smith, Arnett D. Jr.
Solomon, J. Alan
Somerville, Patrick J.
Strickland, Glen
Stringfellow, Jerry B.
Thornton, Charles N.
Tompkins, William Jr.
Turnage, Richard H.
Tyler, Richard L.
Vereen, Lowell E.
Wade, Billy
Warren, William Jr.
Wilhelm, Frieda
Wren, Herbert B.
Wright, James O. III
Yarbrough, Charles P.
Young, Mitchell

Mississippi County
Abraham, Anes Wiley
Abramson, Lawrence
Bell, Mary C.
Biggerstaff, Jerry
Brock, Charles C. Jr.
Cole, Cecil R.
Cullom, Sumner R.
Fairley, Eldon
Fergus, R. Scott
Hall, Leslie
Haynes, Max G.
Hester, Karen Calaway
Hester, Richard
Higley, George B. Jr.
Hubener, Louis F.
Hudson, James H.
Husted, G. Scott
Jones, Herbert
Jones, Joe V.
Lin, Ching-Shan
Melton, Clinton G.
Osborne, Merrill J.
Pollock, George D.
Rauls, Stephen R.
Rhodes, Joseph
Rhodes, R. F.
Rodman, T. N.
Russell, James D.
Shaneyfelt, E. A.
Smith, Ronald D.
Williams, John

Monroe County
Collins, Linda
David, Neylon C. Jr.
Pham, Dac Tat
Pupsta, Benedict F.
Stone, Herd E. Jr.
Walker, Walter L.

Nevada County
Vermont, Charles

Ouachita County
Armato, Andrew A.
Braden, Lawrence F.
Brunson, Milton
Crump, Mark
Dedman, J. L. Jr.
Dedman, William D.
Floss, Robert
Fohn, Charles H.
Guthrie, James
Hout, Judson N.
Jameson, John B. Jr.
Kendall, Jerry R.
McFarland, Gale
Miller, John H.
Mosley, David
Nayles, Lee
Nunnally, Robert H.
Ozment, L. V.
Rayford, Cleveland
Sanders, Cal R.
Thorne, Arthur E.

Phillips County
Barrow, John H. Jr.
Bell, L. J. Patrick
Bell, L. J. Patrick II
Berger, Alfred A.
Epstein, S. Mitchell
Faulkner, Henry N.
Frederick, William Ronald
Kirkman, C. M. T.
McCarty, Charles P.
McCarty, Gordon E. Jr.
McDaniel, Marion A.
Miller, Robert D. Jr.
Paine, William T.
Patton, Francis M.
Rangaswami, Narayanaswami
Tan, Benjamin
Tukivakla, P. Reddy
Vasudevan, Kanaka
Vasudevan, P.
Wise, James E. Jr.

Polk County
Brown, David
Finck, John Henry
Fried, David D.
George, Anthony D.
Lochala, Richard
McClard, Helen
Mesko, John D.
Page, M. Bryan
Rogers, Henry N.
Tinnesz, Thomas
Wood, John P.
Wynn, Chester

Pope County
Ashcraft, Ted
Austin, Nathan
Bachman, David S.
Barron, William G.
Barton, A. Dale
Battles, Larry D.
Beavers, Kevin
Bell, Michael
Bell, Robert A.
Berner, Dennis W.
Birum, Patricia J.
Bost, R. Kingsley
Bradley, Stanley C.
Brown, Charles H.
Burgess, James G.
Callaway, Jody C.
Carter, James M.
Cloud, Joe A.
Crouch, James Jr.
Crumpler, Joe B. Jr.
Dunn, Donald L.
Galloway, William W.
Gately, Stanley
Goodman, Robin Quinn
Haines, Lynn
Harrison, Rick
Hass, Farrell D.
Hendren, Mike
Henry, J. Arnold
Hill, Donald F.
Honghiran, Ted
Jones, Charles Jr.
Kerin, Douglas
Killingsworth, Stephen M.
King, John W.
King, W. Ernest Jr.
Kolb, James M. Jr.
Lawrence, Frank M.
Lovell, Richard K. Sr.
Lowrey, Douglas H.
Lyford, Joe H. Jr.
Malone, George E.
Mauch, E. Jane
May, Robert H. Jr.
Meyer, Kelly H.
Mobley, Max J.
Monfee, Andrew M.
Murphy, David S.
Myers, J. Mark
New, Kenneth O.
Richison, George C.
Riddell, C. Michael
Riley, Don C.
Soto-Figueroa, Sergio F.
Speed, Darrell
Stinnett, Thomas
Stolz, Gerald A. Jr.
Tapley, Thomas S.
Teeter, Stanley D.
Thurlby, W. Robert
Turner, Finley P. II
Turner, Kenneth B.
Wilkins, Charles F. Jr.
Williams, David M.
Young, Sandra S.

Pulaski County
Abbott, William W.
Abel, Lee C.
Abraham, James H.
Abraham, James H. III
Abraham, Robert E.
Adametz, James
Adametz, John
Adamson, James
Alexander, Albert S.
Alford, T. Dale
Allen, Durward Jr.
Allen, E. Stewert
Allen, John E. Jr.
Allen, Thomas
Alston, Phillip
Andersen, Bruce
Angeles, Jana
Aquino, Al
Araoz, Carlos
Archer, Robert L.
Armstrong, Howard
Arnold, David
Arrington, Robert
Atkinson, William Jr.
Ault, Charles C. #
Austin, R. Lee
Baber, John C. Jr.
Baber, John T.
Backus, Joe T.
Bailey, H. A. Ted Jr.
Baker, Glen F.
Baker, John W.
Baker, Johnson
Baker, Yvette
Baldwin, Maxwell R.
Ball, Charles W. Jr.
Ballard, Clarence E. Jr.
Barber, Jeffrey
Barclay, David
Bard, David S.
Barger, Denver L.
Barlow, Brian E.
Barnes, C. Lowry
Barnes, Reginald
Barnes, Robert W.
Barnett, David
Barnett, Troy F.
Barron, Edwin N. Jr.
Barton, Gary
Baskin, Barry
Bates, Ramona
Bates, Stephen
Batres, Francisco
Bauer, F. Michael
Bauer, Frank M. Jr.
Bauman, David C.
Bayliss, John M.
Beadle, Beverly
Bearden, James R.
Beaton, J. Neal
Beck, Joseph II
Becquet, Norbert J.
Belknap, Melvin L.
Bell, Rex H.
Bennett, Eaton W.

Bennett, F. Anthony Jr.
Benton, William
Berry, Frederick B.
Berry, Robert L.
Bevans, David W. Jr.
Bienvenu, Gregory
Bienvenu, Harold G. III
Bierle, Michael
Billie, James
Biondo, Raymond V.
Birkett, Ian McRae
Bishop, Lisa M.
Bishop, William B.
Bitzer, Lon
Black, H. Thurston
Blackshear, Jack L. Jr.
Blankenship, William F.
Blasier, R. Dale
Boehm, Timothy
Boellner, Samuel W.
Boger, James E.
Book, Lindy
Boop, Frederick
Boop, Warren C. Jr.
Bornhofen, John H.
Bost, Roger B.
Bourne, David E.
Bowden, Phillip
Bowen, W. Scott
Bower, Charles M.
Boyd, Charles M.
Boyle, Ronald H.
Bozeman, Barbara J.
Bradburn, Curry B. Jr.
Bradford, J. David
Bradley, Joe F.
Brainard, Jay O.
Brenner, George H. Jr.
Bressinck, Renie E.
Brimberry, Ronald K.
Brineman, John
Brinkley, Roy A.
Brizzolara, A. J.
Brizzolara, John Paul
Broach, R. Fred
Brown, Michael
Brown, Pamela
Brown, Scott H.
Brown, Steven L.
Browning, Donald G.
Browning, Stanley K.
Brunson, Ashley
Buchanan, Francis R.
Buchanan, Gilbert A.
Buchman, Joseph A.
Buchman, Joseph K.
Bucolo, Anthony P.
Budhraja, Meenakshi
Buford, Joe L.
Bumpas, Joe H.
Burger, Robert A.
Burnett, Hugh F.
Burnham, William W.
Burrow, Dennis R.
Byrum, Jerry
Calcote, Robert A.
Calhoon, J. Dale
Calhoun, Joseph D.
Calhoun, Richard A.
Campbell, Gilbert S.
Campbell, James W.
Caplinger, Kelsy J. III
Capps, Dwight II
Carfagno, Jeffrey
Carnahan, Robert G.
Carson, Layne E.
Carter, Jerry L.
Carttar, Charles
Caruthers, Samuel B. Jr.
Casali, Robert E.
Cash, Darlene
Casper, Robert B.
Casteel, Helen
Cathey, Janet
Cathey, Steven
Cavin, Lillian
Chaffin, Raines
Chakales, Harold H.
Chandler, Billy M.
Chang, Chimin J.
Chappell, Carol W.
Cheairs, David B.
Cheairs, John T.
Chisholm, Dan P.
Choate, Robert B.
Christeson, William W.
Christian, John D.
Christiansen, Stephen P.
Chudy, Amail
Church, Marion M.
Church, Michael
Clark, J. Roger
Clark, Richard B.
Clift, Steven A.
Clifton, Cliff
Cobb, Jock S.
Cockrill, H. Howard Jr.
Cogburn, Bob E.
Colclasure, Joe B.
Collins, David
Cone, John
Cope, Michael
Corbitt, Mary
Cornell, Paul J.
Cosgrove, Kingsley W. Jr.
Cosgrove, Lisa
Craig, Marion S. Jr.
Crawford, Cary M.
Crews, J. Travis
Crocker, Charles H.
Cross, J. B.
Crow, Joe W.
Crow, R. Lewis Jr.
Curtner, Byron D.
Davie, Melanie
Davis, Brett C.
Davis, Carole
Davis, Claudia
Davis, Glenn R.
Davis, J. Lynn
DeLoach, John Jr.
Dean, David M.
Dean, Gilbert O.
Deaton, C. William Jr.
Deer, Philip J. Jr.
Deer, Philip James III.
Dennis, James L.
Denson, William D.
DesLauriers, S. Killeen
Dickins, John R. E.
Dickins, Robert D. Jr.
Dickson, D. Bud
Dilday, James 'Kurt'
Dillard, Daniel C.
Diner, Bradley
Dixon, Keith A.
Dodd, Doyne
Doncer, Richard P.
Doucet, Marlon J.
Douglas, Warren M.
Downs, Ralph A.
Dungan, William T.
Dwyer, Gregory A.
Eans, Thomas L.
Easley, Edgar J. #
Easter, Rex M.
Edge, Otis H.
Edmiston, Frank G.
Eisenach, R. Jeffrey
Elders, M. Joycelyn
English, Jim
Evans, Billy
Evans, Scott J.J.
Eyre, Byron L.
Farmer, Joseph F.
Farque, Greg L.
Farris, Guy R. Jr.
Fazekas-May, Mary
Fernandez, Agustin
Ferris, Ernest J.
Fewell, Ronald D.
Fielder, Charles R.
Fields, Patrick R.
Finan, Barre F.
Fincher, Robert L.
Finkbeiner, Alex E.
Fiser, Martin
Fiser, Robert H. Jr.
Fiser, William P. Jr.
Fisher, Robert A.
Fitzgerald, Charles
Fitzhugh, A. Stuart
Flack, James V. Jr.
Flanigan, Stevenson
Flanigan, William
Fletcher, Anthony
Fletcher, Elizabeth D.
Fletcher, Thomas M.
Florez, James P.
Flowers, William C.
Floyd, Bill G.
Foster, Gil
Fraiser, Lacy P.
France, Gene L.
Fraser, Eric A.
Fraser, James H. Jr. #
Frazier, Cynthia
Frazier, G. Thomas
Freeman, Diane
Fuller, C. Dale
Fuller, C. James III
Fulmer, John M.
Galbraith, Robert C.
Gardner, Guy F.
Garst, Neema A.
Gettys, Joseph M. Jr.
Gibbs, Mark
Gibson, Gordon L.
Giglia, Anthony R. III
Giles, Wilbur M.
Gillespie, A. Tharp
Gillespie, James
Gilliam, David
Gist, Charles C.
Glenn, Wayne B.
Glidden, Michael L.
Glover, Lawson E. Jr.
Glover, W. Clyde
Golden, William E.
Goldsmith, Goeffrey
Good, David M.
Good, Henry H.
Gordon, Vida H.
Gosser, Bob L.
Goza, George M. Jr.
Granger, William III
Grant, Karen G.
Gray, Edwin F. #
Green, Benny J.
Green, William O. III
Greenway, C. Don
Greer, G. Stephen
Greutter, John E. Jr.
Grimes, H. Austin
Growdon, James H. #
Guggenheim, Frederick G.
Guin, Jere D.
Hagans, James II
Hagler, James L.
Hahn, Herbert
Hall, A. D.
Hall, A. David
Hamer, Richard A.
Hamilton, George Jr.
Hampton, John R. III
Hankins, Edwin III
Harber, Harley
Hardberger, R. E.
Hardin, Ronald D.
Harger, C. Harold
Hargrove, Joe L.
Harper, Ernest H.
Harper, Gary E.
Harrendorf, Cagle
Harrington, Mariann
Harris, Donald R.
Harris, T. Stuart
Harris, W. Turner
Harrison, A. Vale
Harrison, Roy E.
Harrison, William
Harshfield, David Lee Jr.
Harter, Scott
Hawley, Harold B.
Hayden, William F.
Hayes, J. Harry Jr.
Hayes, John
Hayes, Richard L.
Hayes, Sidney P.
Haynes, W. Ducote
Headstream, James W.
Hearnsberger, H. Graves III

Hearnsberger, Henry G. Jr.
Hearnsberger, John E.
Hedges, Harold IV.
Hedges, Harold H.
Hefley, Bill F.
Hefley, William Jr.
Henker, Fred O. III
Henry, C. Reid Jr.
Henry, Charles R. Sr.
Henry, D. Andrew
Henry, G. Michael
Henry, G. Morrison
Henry, J. Charles
Henry, J. Forrest Jr.
Henry, Richard Y.
Henry, Robert L. Jr.
Henry, William T.
Henson, Gregory N.
Herron, Jerry M.
Herron, John T.
Hickey, Joseph P.
Hicks, David C.
Hicks, David L.
Hixson, Marcia Lynn
Hodges, J. Timothy
Hodges, Steven C.
Hoffmann, Thomas H.
Holland, Jay D.
Hollenberg, Henry G.
Holloway, J. Douglas
Holmes, Harlan C.
Holt, L. Gordon #
Holt, Stephen
Holton, Jerry C.
Hough, Aubrey J. Jr.
Houk, Richard
House, Aniel Jr.
Houston, Samuel
Howell, Coburn S. Jr.
Howell, Marsha T.
Hudson, Thomas F. III
Hughes, Ronald D.
Hundley, John M.
Hundley, Randal F.
Hutchins, Steven W.
Hutson, Harold G.
Jackson, J. Presley
Jackson, Morris A.
Jackson, Thomas
Jansen, G. Thomas
Jefferson, Terry
Johnson, Anthony D.
Johnson, B. Richard
Johnson, Ben D.
Johnson, Carl
Johnson, Dianne Flowers
Johnson, Henry D.
Johnson, M. Bruce
Johnson, Philip H.
Johnston, Dale E.
Jones, Eugene
Jones, Gail Reede
Jones, Garry L.
Jones, John C.
Jones, Kathleen C.
Jones, Robert D.
Jones, Roy
Jones, Sherman
Jones, William N.
Jordan, F. Richard
Jordan, Randy A.
Joseph, Ralph F. II
Joseph, William Frank
Jouett, W. Ray
Joyce, John W.
Junkin, Ruth H.
Kaemmerling, Raymond E.
Kahn, Alfred Jr.
Kane, James J.
Keathley, Susan A.
Keeran, Michael G.
Kellar, Stanley L.
Keller, Alford W.
Kennedy, Charles H.
Kennedy, Eleanor E.
Kennedy, H. Frazier
Key, J. Michael
Kilgore, Reed W.
King, Michael T.
King, William D.
Kittler, Fred J.
Kizziar, Jim C.
Klein, E. F. 'Bud' Jr.
Klimberg, V. Suzanne
Knott, Patricia A.
Knox, Michael F.
Kolb, Agnes J.
Kolb, W. Payton
Koonce, Thomas W.
Kovaleski, Thomas M.
Kozberg, Oscar
Kozlowski, Karen J.
Kramm, Paul C.
Krulin, Gregory S.
Kumpuris, Andrew G.
Kumpuris, Dean
Kumpuris, Frank G.
Kyser, James F.
Laakman, Robert W.
Lam, Bryon L.
Lambert, Robert A.
Landers, James H.
Landgren, Robert C.
Lane, John W.
Lang, Nicholas P.
Langston, Harold D.
Laurenzana, Donald A.
Lawson, Mason G.
Lea, Allen K.
Lehmberg, Robert W.
Leibovich, Marvin
Leonard, Donald G.
Leou, Frank J.
Lewis, Derek
Lewis, W. Sexton
Lile, Henry A.
Lincoln, Ben M.
Lipke, Jay M.
Loebl, Edward C.
Logan, Charles W.
Love, Tommy L. Jr.
Lowe, Betty A.
Lucy, Dennis D. Jr.
Ludwig, Frank R.
Lyons, Virgle E. Jr.
Mabrey, William
Magie, Stephen K.
Malak, F. A.
Mallory, John A.
Maloney, F. Patrick
Maners, Ann
Mann, R. Jerry
Markland, Gary S.
Marks, Stephen R.
Martin, Kenneth A.
Martin, Richard H.
Martin, Robbie
Mason, J. Zachary
Mason, William L.
Matthews, Joseph W.
Matthews, Robert R. #
McAdoo, Hosea W. Jr.
McCarthy, Richard E.
McConnell, John D.
McCracken, Gail Ann
McCracken, John
McCrary, George A.
McCutcheon, Frank B. Jr.
McDonald, James E.
McDonald, Judy
McDonald, William Glen
McGowan, Robert Jr.
McGrew, Robert N.
McGriff, Lloyd
McKelvey, K. David
McKinney, Carl
McKnight, C. Allen
McMillin, F. Lamar Sr.
McNair, James R.
McNee, Valerie
Meacham, Donald F.
Meador, Annette Parker
Meadors, Frederick
Means, Paul N.
Medlock, Rickey D.
Mellor, Roy II
Mendelsohn, Lawrence A.
Metrailer, James A.
Meziere, Tom
Middaugh, Riley Ann
Miers, Jane F.
Miles, David A.
Miller, Forrest B. Jr.
Miller, Raymond P. Sr.
Milner, E. L.
Mitchell, George K.
Mizell, Philip
Mizell, Walter S.
Moffett, Robert Jr.
Money, Wandal D.
Montanez, Josue
Mooney, Donald K.
Moore, Burton A.
Moore, J. Malcolm Jr.
Moore, Michael
Moore, Rex N.
Moore, Robert B.
Moore, Thomas
Morris, Barbara
Morris, Paula
Morris, W. Dale
Morrison, Debra F.
Morrison, Lynn
Morse, James C.
Morton, William J.
Mulhollan, James S.
Mundie, J. Ryland
Murphy, Bruce
Murphy, James E. Jr.
Murphy, Jeanne
Murphy, Joseph
Murphy, Randolph
Murphy, Robert
Murphy, Tena
Nagel, Fred G.
Nash, John C.
Nelson, Alvah J. III
Nelson, Carl L.
Nestrud, Richard M.
Newbern, David
Newsum, Jon Kirby
Newton, Fred E.
Nix, Richard A.
Nokes, Steven
Nolen, James E.
Norton, George A.
Norton, Joseph A.
Nowlin, James Bill
Nugent, Richard
O'Neal, Walter H.
Oates, Gordon P.
Oddson, Terrence A.
Ogden, Mahlon D.
Oglesby, Walter R.
Osam, Patrick N.
Osteen, Paul
Owings, Debra
Owings, Richard
Ozment, Kerry
Padberg, Frank T.
Paddock, George
Padilla, Fernando
Pappas, James J.
Parker, J. Mayne
Parkhurst, James
Parks, Greta
Parmley, Tim
Parnell, Clifton L. III
Paulus, Thomas E.
Pearce, Charles
Peeples, R. Earl
Peters, John E.
Peters, Phillip J.
Petrus, Gary M.
Petursson, Gissur J.
Pevahouse, Joe
Phillips, Bert L. #
Phillips, Charles E.
Phillips, Hannah
Phillips, James R.
Pierce, William
Pike, John D.
Pledger, Norman R.
Pollard, Arlee E.
Pope, Norton A.
Porter, Robert Jr.
Potts, Jerry L.
Power, Robert C.
Prather, Jerry L.
Price, Ben O.
Pringos, Andrew A.
Purdy, Harold D.

Pyle, Hoyte R. Jr.
Quirk, J. Gerald
Ransom, John M.
Raque, Carl J.
Rector, Nancy F.
Reding, David L.
Redman, John F.
Reed, Ewing C. Jr.
Reese, William G.
Reid, Gene W.
Remmel, Raymond
Rice, Charles
Rice, James Curtis
Riddle, John F. Jr.
Riegler, N. W. Jr.
Riley, William H.
Ritchie, Robert Ross
Robbins, Kenneth
Roberson, Michael C.
Roberts, Kevin
Rodgers, C. Dudley Jr.
Rodgers, Charles H.
Roman, Anthony
Rooney, Thomas P.
Rosenbaum, Carl A.
Ross, Ashley Sloan
Ross, Cynthia
Ross, Robert W.
Ross, S. William
Rothert, Frances C.
Rounsaville, Harry L.
Rouse, Lucien Jr.
Roy, F. Hampton
Ruggles, Dwayne L.
Runyan, William A.
Russell, James B.
Rutherford, Reginald J.
Rutledge, William L.
Saer, Edward H. III
Sanderson, Marvin
Satre, Richard W.
Satterfield, John V. III
Schlesinger, Scott Michael
Schlicht, Lisa
Schmitz, Susan
Schock, Charles C.
Schratz, Bruce E.
Schroeder, George T.
Schultz, John C.
Schutz, Michael J.
Schwander, L. Howard
Scruggs, Jan W.
Searcy, Robert M.
Seibert, Joanna J.
Seibert, Robert
Selakovich, Walter G.
Sessions, Louis II
Sexton, Jon A.
Shannon, Robert F. #
Sheppard, Joseph
Shock, John P.
Short, Harold K.
Shotts, Joseph
Shuffield, James
Silvoso, Gerald R.
Simmons, Orman W.
Simpson, N. Henry Jr.
Sims, James M.
Singer, Peter
Singleton, L. Gene
Sinor, Elicia
Sipes, Frank M.
Skokos, C. Kemp
Slater, John G. Jr.
Slaven, John E.
Slayden, John E.
Sloan, Fay M.
Sloan, James M.
Smart, Douglas F.
Smelz, Johnny
Smith, Aubrey C.
Smith, Charles W. Jr.
Smith, David E.
Smith, Douglas B.
Smith, G. Richard Jr.
Smith, James L.
Smith, Mose III
Smith, Purcell Jr.
Smith, Thomas J.
Smith, Thomas W.
Smith, Tom
Somers, A. Jack
Sorrells, R. Barry
Sotomora, Ricardo F.
Squire, Arthur E. Jr.
St Amour, Thomas E.
Stair, J. Michael
Stallings, Walt
Stanley, Joe P.
Stanley, Robert
Stanton, T. Michael
Steele, William L.
Stefans, Vikki Ann
Stern, Scott Jeffrey
Sternberg, Jack J.
Stewart, Daryl
Stokes, Bernard
Stone, Van D.
Storeygard, Alan R.
Stotts, John R.
Stout, Kimber
Strauss, Mark
Strode, Steven W.
Stroope, George F.
Studdard, James D.
Sturdivant, Stephen
Suen, James
Sulieman, J. Samir
Sullivan, Charles D.
Sullivan, Jan R.
Sundermann, Richard H.
Swindoll, Bryant S.
Tabor, Marcella A.
Talbert, Gary Eugene
Talbert, Michael
Tamas, David E.
Tanner, James A.
Taylor, David R.
Taylor, Eugene H.
Tedford, John G.
Teplick, Steven
Texter, E. Clinton Jr.
Thomas, A. Henry
Thomas, Peter O.
Thompson, A. Reed
Thompson, John R.
Thompson, S. Berry Jr.
Thompson, Steven M.
Thomsen-Hall, Kathleen
Thorn, G. Max
Tilley, Steve
Towbin, Eugene J.
Tracy, Phillip A.
Tranum, Bill L.
Tressler, Samuel D. III
Trussell, Thomas W.
Tseng, Jyi-Ming
Tucker, R. Stephen
Tucker, W. Everett
Valentine, Robert G. Jr.
Vaughter, W. Roger
Velez, Duane
Verma, Virendar K.
Vinsant, Kurtis
Vogel, Robert G.
Vyas, Dileepkumar R.
Wade, William I. Jr.
Wagoner, Jack
Walker, Lee
Walker, Ronald
Walt, James R.
Waner, Milton
Ward, Harry P.
Ward, Joseph P.
Ward, Thomas
Warford, Walton R.
Watkins, Charles J.
Watkins, John Jr.
Watkins, John G. III
Watkins, Julia
Watkins, Larry S.
Watson, C. Robert
Watson, Charles
Watson, Daniel W.
Watson, Vye B.
Weber, Edward R.
Weber, James R.
Weber, Michael
Weiss, David W.
Weiss, Gerald N.
Welch, Samuel Bradley
Wellborn, James C. Jr.
Wellons, James A. Jr.
Wende, Raymond A.
Wenger, Carl E.
Westbrook, Kent C.
Westerfield, Frank M. Jr.
White, Oba B.
Wilkes, Elbert H.
Wilkes, T. David I.
Williams, Alonzo D.
Williams, C. David
Williams, G. Doyne Jr.
Williams, Ronald N.
Williamson, Arian III
Wills, Pamela
Wilson, Elaine
Wilson, Frances C.
Wilson, Frank J. Jr.
Wilson, I. Dodd
Wilson, James M.
Wilson, James W.
Wilson, John L.
Wilson, R. Sloan
Wirthlin, Laurie Sue
Wolverton, John
Workman, W. Wayne
Wortham, Thomas H.
Wyatt, Richard A.
Yamauchi, Terry
Yocum, John
Young, Douglas E.
Zelnick, Paul
Zuerlein, Terrance

Randolph County

Baltz, Albert L.
Baltz, Mark
Barre, Hal S.
DeClerk, Thomas
Holt, Danny B.
Jansen, Andrew J. III
Mize, James S. #
Scott, William W.
Smith, Norman K.
Smoot, John D.

Saline County

Ashby, John W. #
Ashby, Robert
Baber, Quin M.
Bethel, James
Burton, Charles R.
Caldwell, David L.
Cash, Ralph D.
Coker, S. Dale
Cooper, James B.
Cornwell, Samuel L.
Council, Robert A. Jr.
Dockery, Melissa
Duncan, J. Shelby
Eaton, James M.
Gardner, Dan R.
Hill, Edward B.
Hill, Howell V.
Hogue, F. Paul
Izard, Ralph S. Jr.
Johnston, Greg
Kirk, Marvin N. Jr.
Martindale, J. L.
Martindale, Mark A.
Ramsay, Rex C. Jr.
Stewart, David L.
Sudderth, Brian F.
Taggart, Sam D.
Thibault, Frank G. Jr.
Thomas, Bill R.
Thorn, Harvey Bell Jr.
Tilley, Roger L.
Viner, Donald L.
Wagner, Taylor
Watson, Kirk D.
Wright, John D.

Sebastian County

Acklin, Jimmy D.
Albers, David G.
Alberty, Joe
Anderson, Paul
Atkins, Jimmie G.
Bailey, Charles W.
Baker, Max A.

Ballard, Robert L.
Barker, Robert Jr.
Barr, Marilyn
Barry, James Jr.
Beachy, Allen L.
Bell, Timothy
Berryhill, Richard E.
Berumen, Mike
Best, Timothy R.
Bise, Roger N.
Bordeaux, Ronald A.
Bouton, Michael
Bradford, A. C.
Brown, Byron L.
Brown, James A.
Brown, Richard
Buie, James H.
Builteman, Cynthia
Builteman, James
Burks, Deland
Burt, William J.
Busby, J. David
Cain, Martin
Carson, Randall L.
Carter, D. Mike
Cassady, Calvin R.
Chambers, Donald
Chester, Robert L.
Cheyne, Thomas
Coffman, Edwin L.
Coleman, Michael D.
Craft, Charles
Crow, Neil E. Sr.
Crow, Neil E. Jr.
Culp, William C.
Daily, Richard
Davenport, O. Leo
Deaton, John M.
Deneke, James S.
Dorzab, Joe H.
Drolshagen, Leo F. III
Dudding, William F.
Edwards, Gary
Ellis, Homer G.
Ennen, Randy
Everett, Karen
Faier, Samuel
Feder, Frederick P. Jr.
Feezell, Randall E.
Feild, T. A. III
Felker, Gary V.
Ferrell, Jeffrey
Fineberg, Daniel
Fisher, Robert D.
Flippin, Tony A.
Floyd, Charles H.
Francis, Darryl R. II
Franz, F. Perry
Gamble, Cory
Gedosh, Edgar A.
Gill, James A.
Girkin, R. Gene
Glover, D. Bruce
Goodman, R. Cole Jr.
Goodman, Raymond C. Sr.
Graves, Stephen C.
Griggs, William L. III
Gwartney, Michael P.
Hamilton, Lance
Hanley, Larry L.
Harmon, Pamela
Hathcock, Alfred B.
Heim, Stephen
Hendrickson, Jon
Hendrickson, Kathryn D.
Henry, James
Herren, Adrian L.
Hewett, Archie L.
Hoffman, John D.
Hoge, Marlin B.
Holland, Jerry
Holman, William A.
Holmes, Williams C. Jr.
Hornberger, Evans Z. Jr.
Howell, James T.
Hughes, Robert P. Jr.
Hunton, David W.
Hunton, Teresa H.
Huskison, William T.
Hyde, Marshall L.
Ingram, Ralph N.
Irwin, Peter J.
Jaggers, Robert
Janes, Robert H. Jr.
Jefferson, Christina M.
Jefferson, Thomas C.
Jones, Greg T.
Jones, W. Duane
Kareus, John L.
Kelly, Thomas C.
Kelsey, J. F.
Kientz, John Jr.
Klopfenstein, Keith
Knight, William E.
Knobloch, Ronald
Knox, Robert
Knubley, William A.
Kocher, David B.
Koenig, A. Samuel III
Koenig, Albert S. Jr.
Kradel, R. Paul
Kraemer, Soren R.
Kramer, Ralph G.
Kutait, Kemal E.
Lambiotte, Louis O.
Landherr, Edwin
Landrum, Annette V.
Landrum, Samuel E.
Lane, Charles S. Jr.
Lange, John L.
Lavery, John
Lenington, Jerry O.
Lewing, Hugh S.
Lilly, Ken E.
Lockwood, Frank M.
Long, James W.
MacDade, Albert D.
Magness, Jack L. Jr.
Manus, Stephen C.
Martimbeau, Claude
Martin, Art B.
Martin, Rick
Masri, Hassan M.
Maxey, Harold
McClain, Merle
McClanahan, J. David
McCraw, Gordon
McEwen, Stanley R.
McKinney, Robert
McMinimy, Donald
Meador, Don M.
Miller, Robert C.
Mings, Harold H.
Moulton, Everett C. Jr.
Moulton, Everett C. III
Mumme, Marvin E.
Murphy, Anne L.
Muylaert, Michel
Nassri, Louay
Nelson, Steve B.
Nichols, David R.
Niemann, Jeffrey M.
Nolewajka, Andre J.
Olson, John D.
Paris, Charles H.
Parker, Douglas W. Jr.
Parker, Thomas G.
Patrick, Donald L.
Payson, Tony A.
Pearce, Larry W.
Peluso, Francis
Pence, Eldon D. Jr.
Phillips, Don
Phillips, Kevin Clark
Phillips, Sumer
Phillips, W. P.
Pillstrom, Lawrence G.
Poe, McDonald Jr.
Poole, M. Louis
Pope, John R.
Post, James M.
Prewitt, Taylor A.
Price, Lawrence C.
Rabideau, Dana P.
Raby, Paul L.
Raymond, Thomas H.
Rivera, Raul
Robinson, Ronald P.
Rosenzweig, Kenneth
Russell, Rex D.
Saviers, Boyd M.
Schemel, William H.
Schroeder, Cygnet
Schwarz, Julio
Schwarz, Paul R.
Sherman, Robert L. #
Sherrill, William M. Jr.
Smith, Herbert T.
Smith, Kent
Smith, Terrald J.
Snider, James R.
St.Clair, Kevin
Standefer, J. Michael
Stanton, William B.
Stewart, Jerry R.
Stewart, John B.
Still, Eugene F. II
Stillwell, Mark
Studt, James
Swicegood, John R.
Taft, Eileen
Taft, Eric
Tait, Amy
Thompson, J. Kenneth
Thompson, Robert J.
Torres, Stephen
Trent, Judy
Turner, William F.
Van Asche, Christopher
Vanderpool, Roy E.
Vernon, Rowland P. Jr.
Waack, Timothy
Wahman, Gerald E.
Wallace, Kenneth K.
Ward, Sanford
Webb, William K.
Weisse, John J.
Wells, John D.
Westbrook, Michael R.
Westermann, Norman F.
White, J. Earle III
Whiteside, Edwin
Wikman, John H.
Williams, Carl L.
Wills, Paul I.
Wilson, Morton C.
Wilson, Steven K.
Wolfe, Michael S.
Woods, Leon P.
Zufari, Munir M.

Sevier County

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Hoyt, Jonathan
Jones, Charles N.
Mielnick, Alina

St. Francis County

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Conner, George
Crawley, Charles E.
DeRossitt, James P. III
Fong, Fun Hung
Hammons, Edward P.
Lopez, Ramon E.
McGuire, Samuel A. III
Meredith, James Jr.
Schwartz, Frank R.

Tri-County County

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Arnold, Griffin II.
Benton, Thomas H.
Bozeman, Jim G.
Campos, Louis
Ducker, David E.
Grasse, A. Meryl
Grasse, John Jr.
Heise, Lawrence F.
Jackson, George W.
Krygier, Albin J.
Lane, Robert C.
Moody, Michael N.
Pembrook, Richard
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Tatum, Harold M.
Wright, Donald

Union County

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Barenberg, Robert
Bass, Edward J.
Bevill, Gary L.
Booker, J. Gregory
Bowman, Raymond N.
Callaway, James C.
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Cyphers, Charles D.
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Dougherty, Bert
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Elliott, Wayne G.
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Fitch, Leston E.
Forward, Robert B.
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Menendez, Moises A.
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Turnbow, R. L.
Ulmer, Minna Irene
Vasan, Srini
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Brown, David L.
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Davis, Randall
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Davis, Scott A.
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de Saint Felix, Douglas
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Ehret, Roger
Ehret, Rose
Ekanem, Felix
Ellis, Dean
Ellis, Mark
Emanuel, Peter
Embry, Travis D.
Espinoza, Jude
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Fegan, Jeff
Flanigin, Richard
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Forte, Kevin
Frazier, Ronald K.
Gairhan, Charles
Gierach, Cynthia
Gillespie, Elaine

Gilmore, Barry
Glasco, Gerry B.
Glassman, Anthony
Gober, Gregg
Good, Tina
Gordon, Alfred Y. Jr.
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Govindarajan, Rangaswamy
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Haider, Riaz
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Hall, Scott
Hardy, Kyle G.
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Harris, Patricia
Hathcock, Stephen A.
Haut, Paul R.
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Haws, Karl W.
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Horan, Michelle
Houchin, Vonda
Hubach, Cindy
Hughes, Alan W.
Hughes, Mark
Hughes, R. Hal
Hunt, Randall Evan
Hurlbut, Kevin
Hurlbut, Kimberly
Ick, Kurt
Ironside, John
Ivy, Donald
Jacobs, John
Jain, Parker
Jeffries, Robert
Jensen, Joseph
Johnson, Kelli
Jones, Olcay
Jones, Steven
Jordan, Raymond
Julka, Sudhir
Kamdar, Vikram
Kelly, Dennis Jr.
Kelly, Kathleen
Keplinger, Florian
Khan, Shagufta P.
Kibodeaux, Jacquelyn
Kim, Nam
Kinsinger, John W.
Kirchner, JoAnn
Kiser, Pamela
Kiser, Thomas
Klasner, Ann
Klasson, Stephen C.
Knapple, Whitfield
Krebel, Meredith
Krebel, Steven R.
Kuhn, Ronald
Kuykendall, Scott
Landwehr, Lawrence
Langston, James David
Lansford, Bryan
LaPietra, Jesse Jr.
Le, Dung N.
Letcher, Charles
Levine, Jeffrey
Lewis, Charles
Lewis, William
Libuit, Noel
Lile, Scott A.
Lindstrom, Philip
Lintecum, Neal D.
Little, J. Aaron
Liu, George
Love, Jon
Love, Joseph E.
Lowery, Ronald
Lyle, Robert
Malik, Salman
Manley, Susan
Marotti, A. Scott
Martin, Robert H.
Martin, Ronald J.
Massey, Samuel O. III
Masterson, Robert C.
Matchett, W. Jean
Maxson, Suzanne
Maxson, Todd
Mays, Kevin P.
McAlister, Robin
McCann, Ronald Jr.
McElroy, Kellye
McGaugh, Ronald C. Jr.
McKee, Sanders
McLendon, Kristi
Meyer, Lawrence H.
Mirza, Muhammed
Mitchell, J. Keith
Molpus, William
Montgomery, F. Renee'
Montgomery, Lori
Montgomery, Sarah
Moran, Kevin
Moran, Sean
Mosher, Lisa
Mullens, Mark
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Nesmith, James D.
Nguyen, Duong
Nichol, Brian
Nichols, Sandra D.
Nichols, Scott
North, Paula
Ohlhausen, Ward W.
Ort, Michael E.
Owen, Kip
Palesano, Richard
Parker, Ray Jr.
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Phinney, Dawn L.
Pickert, Curtis B.
Pirich, Laura
Pohle, Floyd
Poole, Charles
Pope, David
Porter, Martin
Price, Claire
Pruitt, Tad
Pryor, Shapard Jr.
Quinn, John III.
Qureshi, Waqar A.
Radcliffe, Joan Krajca
Rader, George
Rahman, Salim
Ramdat, Kenneth
Ramsey, Bruce
Reese, Valerie
Reinhart, Jeffrey
Reis, Ivory
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Richter, Gregory A
Rimmer, Douglas Jr.
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Rish, James
Robbins, Mark
Robinson, Matthew
Rogers, Marc
Roppolo, Michael Wayne
Rosa, Regina
Roser, Steven
Rothrock, Perry III
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Ruble, Richard C. II.
Ruddell, Deanna N.
Russell, Anthony E.
Saidi, Johnaqa
Salman, Marsha
Schaffner, Randall
Schauder, Craig
Schexnayder, Stephen M.
Schmitz, James
Schonefeld, Michael D.
Schonefeld, Pamela
Scott, A. DeMarques
Scruggs, Tonya
Seguin, Rosa
Sharkey, Paul Jr.
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Shepard, Shelley
Sherwood, Edwin
Shumate, Linda
Slaven, John
Smith, Amy S.
Smith, Leslie
Snow, Lisa
Sowell, John K.
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St.Pierre, Mark
Steely, Donald
Stepp, Robert
Stewart, Jimmie III
Stewart, Tracy D.
Stills, David
Tackett, Lee Jr.
Tahiri, Abdalla A.
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Thomas, Donald Jr.
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Thomas, Stuart
Thomason, Steven L.
Thorn, Garland M. Jr.
Travis, Patrick
Troxel, Roger
Trussell, Anne
Turner, Sammy
U, Tha
Ulmer, Sue
Ureckis, David
Urrutibeheity, Gisele
Van Hemert, Rudy
Velusamy, Muthusamy
Vice, Mark
Vitti, Michael
Wallis, Mark
Waters, Samuel
Watson, Paula
White, Edward
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Wilson, Mark
Wilson, Matthew
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Woodson, Mark
Worley, Mark
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Chi, Jasen C.
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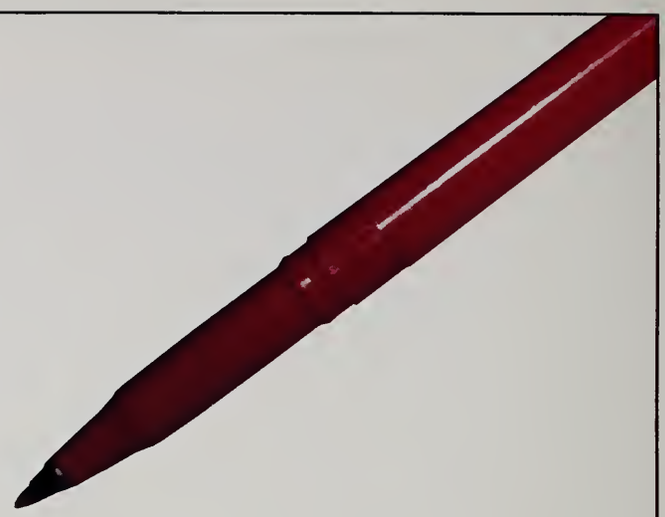

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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Ruminations

Gilbert O. Dean, M.D.

At the Wednesday noon luncheon meeting of the Senior Physicians of Arkansas, Tom Feurig was discussing the many characteristic features and vagaries associated with St. Vincent Infirmary. When he stated that the average per day cost of a patient in the hospital is about six hundred dollars, (Medicare or private), memories began to flood through my mind. Those memories were hinged around the government's 1967 establishment of Medicare as a permanent fact.

First came a short reminiscence about the surgery patient whose 1957 hospital bill for a ten day stay after gall bladder surgery was five hundred dollars. She was ruminating when she told me that fifteen years before, a ten day hospital stay for her first delivery cost her fifty dollars. I also remembered that those were the days when the best care given to my post-op patients was on five west ward in the old Baptist Hospital, where the daily cost per patient day was five dollars.

From five dollars to six hundred dollars for a day's hospital care! From twelve hundred dollars to twenty-two thousand dollars for a new Oldsmobile! From one penny to fifteen cents for a tiny individually wrapped piece of candy! Those and other memories evoked an unpleasant recollection about my first invlovement with Medicare. I shall explain!

The medical profession as a whole became resistant to the government's idea of social security and Medicare. Many wise old practitioners rightly felt that these governmentally sponsored plans were actuarilly unsound. During this early period of Medicare, I was honored by being elected president of the Pulaski County Medical Society. I was also serving a two-year term as Chief of Staff at St. Vincent's Infirmary.

In order to evaluate as well as publicize the pros and cons of the newly established Medicare system, a noon luncheon was held at the Sam Peck Hotel. About forty people were present at the luncheon and they included several hospital administrators, Blue Cross insurance executives, local government representatives, civic club members and officers, newspaper reporters, and anyone knowledgeable or interested in the problems that might arise with the newly implemented Medicare regimen. As president of the Pulaski County Medical Soceity, I was asked to present the Medical profession's views as to how Medicare would work, its impact on the practice of medicine and society in general. Loaded with data from the American Medical Association which was apprehensive about this massive much feared program as well as my own medical background, I was glad to speak out.

Although my address did not cover many of the advantages and disadvantages of Medicare that would be experienced by patients, hospitals and doctors during the next thirty years, it did cover three elements of knowledge. First, I told how my medical school's clinical professors had taught that in the private practice of medicine and surgery, thirty percent of all patients would be totally charity cases, unable to pay, and that only seventy percent of the cases would pay for service rendered. In my own private practice I had found those teachings to be true; and like all doctors of that period, I gladly rendered the same quality of service to my charity patients that I gave to those who paid their medical bills. This was a system that had worked for a long time.

Secondly, I recited a number of AMA criticisms about the Medicare proposals that were being instituted. The

AMA data noted that standard fees would be paid for all services rendered to all Medicare recipients regardless of their own financial status or ability to pay. Whereas I had done the charity cases for nothing and charged the young worker fifity dollars for an appendectomy or hemoplasty and the banker or successful business man one hundred and fifty dollars for the same operation, the government would now pay eighty percent of one hundred and fifty dollars on the usual and customary fee. The AMA data stated that such a system could encourage doctors to profiteer from its impartial bureaucratic administration of payments for medical care.

Thirdly, the AMA, all the physicians and everyone I had talked to stated that the Medicare system being implemented was bound to increase inflation. Inflation was evident in my 1942 Oldsmobile for which I paid twelve hundred dollars as I entered the Naval Reserve program in World War II. Five years later in 1948, I received eighteen hundred dollars for the 1942 Oldsmobile in trade-in value on a new Oldsmobile. As an example of real inflation, I further related my experience with the Chinese dollar, which like the Mexican peso, had been valued at two coins for an American dollar before World War II. While staying (in 1945) for three days at the Peking Hotel, I went to a hotel bank and changed an American five dollar bill into twenty thousand Chinese dollars. Then I went around the corner to a hotel restaurant and paid twenty-nine hundred Chinese dollars for a meal that I could have bought for sixty-nine cents in the United States. When I completed my talk I received gracious applause and thought that I had made a useful and convincing statement. A few days later however, I received this letter:

April 13, 1967

Dr. Gilbert Dean
President, Pulaski County Medical Society
Donaghey Building
Little Rock, Arkansas

Dear Dr. Dean:

I was very surprised to see you quoted in last night's paper as saying physicians were "profiteering" off Medicare. I'm curious as to your definition of the term "profiteering" as well as your source of information upon which to base such a statement. If these "profiteers" are local physicians I would have thought your first step should have been to talk with the physicians involved, secondly to bring such facts as you have to the attention of the county society for referral to the appropriate committee and lastly, if at all, take it to the lay press.

I'm sure your are as concerned as I am with such misconduct and I feel our society must take appropriate action through proper channels to put a stop to any profiteering on the part of our colleagues. But I am equally concerned with the publicity which your statement has brought to our medical community. It is, to me, the most serious slap the profession has had in the press in recent years and could do consideralble harm to the profession – even nationwide.

I was surprised you would make it – and still can hope you were misquoted since I know things like that happen – and even more surprised that the Public Relations Committee would condone such a statement.

In my opinion our society is now obligated to thoroughly investigate the facts you relied upon and do our best to correct the situation and to let the public know of our actions.

Sincerely,

Robert F. Shannon, M.D.

cc: Mr. Paul Harris
Dr. Amail Chudy, Chairman, Public Relations Committee

RFS:dc

Needless to say, I was shocked by Dr. Shannon's letter and criticism. At that time his father, Karr Shannon, was one of the editors of the Arkansas Democrat and he kindly sent one of his reporters to interview me and allow me to publicly rescind my statement about doctors profiteering. Some amenities resulted from that interview, but I have retained a hesitancy to ever proclaim publicly any strong opinions about government policies as related to medical care. Dr. Bob Shannon and I remained good friends, and I am saddened by his recent tragic illness and death.

During the early years of Medicare, I was asked on two occasions to submit a list of my fees that I charged for various surgical procedures. On another occasion while serving on a fee scheduling committee for Blue Cross/Blue Shield, I was asked to submit a list of potential fees to be paid for a number of the procedures necessary in the prolonged treatment of patients with severe burns. I also practiced for thirty-nine years while my fees for gall bladder surgery escalated from one-hunderd-fifty dollars to fifteen hundred dollars. Charges for an appendectomy or hemoplasty, that I once gladly did for fifity dollars, were being approved for four-hundred dollars or more in 1984, when I retired.

Several recent newspaper articles about doctors who have perpetrated fraud in their charges submitted for Medicaid and Medicare patients, as well as numerous complaints from doctors who have been caught up in the changing rules that the government makes on Blue Cross, hospitals and physicians have made me sadly shake my head and say, "I told you so!"

Now Medicaid! Oh dear! Oh dear!■

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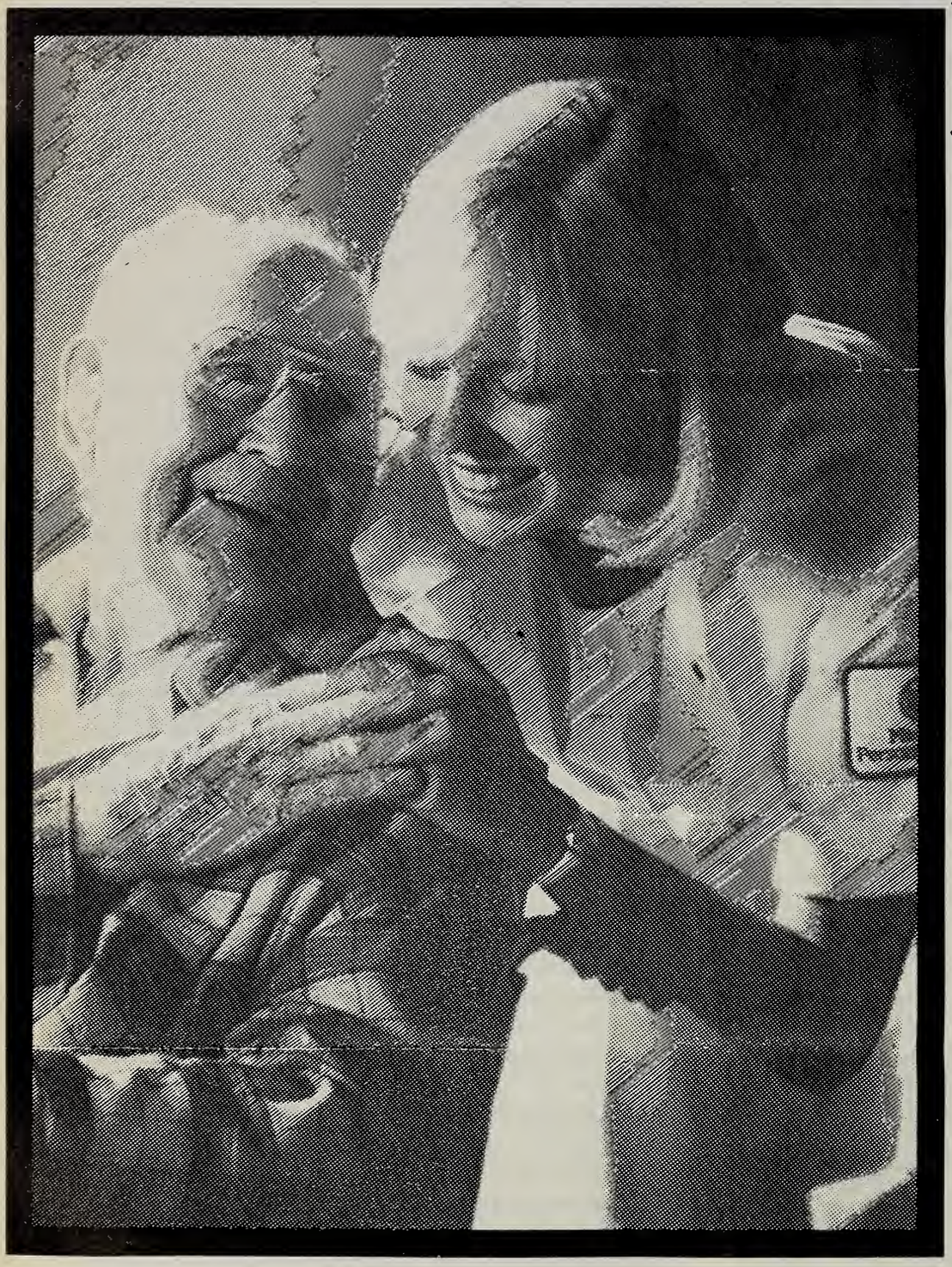

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Laparoscopic Cholecystectomy in Pregnancy: Contraindicated or Indicated?

A.H. Rusher, M.D., F.A.C.S.*
Brad Fields, M.D., F.A.C.O.G.**
Kelton Henson, M.D.***

Laparoscopic cholecystectomy has proven to be superior to traditional open cholecystectomy in uncomplicated cases of cholecystitis. The patients experience less pain with less need for narcotics, fewer incisional complications, earlier postoperative ambulation, and a shorter hospitalization. It is our opinion that pregnancy, previously considered an absolute contraindication to laparoscopic cholecystectomy, is now an indication for laparoscopic cholecystectomy in select patients. We describe one of our cases of laparoscopic cholecystectomy during pregnancy. The patient was at 17 weeks gestation and had an unremarkable procedure and a recovery similar to that expected for a non-pregnant patient. Review of current literature has shown that this procedure can be done safely and with an excellent outcome for both the patient and her fetus.

It has been stated that pregnancy is an absolute contraindication to laparoscopic cholecystectomy! Reasons for this policy have been unsubstantiated thus far. The technique of laparoscopic cholecystectomy is relatively new and it has understandably been recommended for use in a conservative fashion until broad experience has been accumulated. There are several reasons why we believe that laparoscopic cholecystectomy should be the technique of choice in selected pregnant patients. The following case report is illustrative of the reasons for our opinion.

A 24 year old white female presented at 17 weeks gestation with moderately severe epigastric and right upper quadrant pain, nausea, and vomiting. She was not febrile and icteric. She had previously delivered vaginally two healthy infants on two separate pregnancies. An ultrasound examination revealed two small gallstones, non-dilated biliary ducts, no pericholecystic fluid, and no thickening of the gallbladder wall. Her WBC was 14,900 but the SGOT, alkaline phosphatase, amylase, and urine were all normal.

Because of pain unrelieved over a twelve hour period, a laparoscopic cholecystectomy was done under general anesthesia. After decompressing the stomach and bladder, we insufflated the abdomen with a Veress needle through a small linear incision within the umbilicus. Four trocars were placed in standard positions for the laparoscopic and operative instruments. Under direct vision, we isolated the cystic duct and cystic artery. They were doubly clipped proximally and singly clipped distally before being divided with scissors. The gallbladder was then dissected from the liver bed with electrocautery. It was removed from the umbilical port in standard fashion. The gravid uterus was seen and appeared normal. No manipulation of the uterus or adnexal structures was required. The ports were removed and the wounds were closed with subcuticular vicryl sutures. No drains were used. The procedure and the postoperative recovery were uneventful. Fetal heart tones were normal the following day at the time of discharge.

Discussion

Next to appendectomy, the most frequent non-obstetric surgical procedure performed on pregnant patients is cholecystectomy. Fortunately, acute cholecystitis occurs

* Dr. Rusher is a General Surgeon in Jonesboro.
** Dr. Fields is an OB/GYN in Jonesboro.
*** Dr. Henson is a resident at the Area Health Education Center in Jonesboro, Arkansas.

with a frequency of on 3 to 6 per 10,000 pregnancies. The incidence of gallstones is certainly more frequent in this population but they remain asymptomatic through the gestational period for most women. Whether the frequency of cholecystitis is increased by pregnancy or not over non-pregnant counterparts is not clear. There are however four conditions during pregnancy which affect the biliary system as a result of the progesterone effects:

1. There is an increased fasting volume of bile in the gallbladder.
2. There is an increased residual volume of bile in the gallbladder after it is "emptied" (i.e. a decreased response to cholecystokinin.)
3. There is an increased saturation of cholesterol in the bile.
4. There is a decreased circulating bile salt pool.

All of these factors predispose to new stones or augment old stone formation.

The diagnosis of cholecystitis in pregnancy is made clinically with verification from ultrasound. The differential diagnoses include acute peptic ulcer, pancreatitis, hepatitis, pneumonia, pyelonephritis, early herpes zoster and appendicitis. The historical course of treatment for cholecystitis has been conservative using nasogastric suctioning, IV fluids, narcotics for pain and antibiotics if needed for infection. Surgery has been used only for frequent repeated attacks of biliary colic, for failure to respond to medical therapy, for perforation, toxicity, or jaundice, for difficulty controlling diabetes mellitus, and when the diagnosis is unclear but the patient is failing to improve. There has been no apparent increase in maternal mortality from surgery for uncomplicated gallbladder disease and only a 5% fetal mortality in that condition. However, with pancreatitits, maternal mortality increases to 15% and that for the fetus is up to 60%.

Any surgery during pregnancy is best performed during the second trimester. During this period, spontaneous abortion is less likely, organogenesis is nearly complete, and the uterus is not yet large enough to interfere with visualization of important anatomical structures. The obvious benefits of laparoscopic cholecystectomy are lessened morbidity, more rapid recovery with early ambulation and improved ventilation and nutrition, less fetal depression from postoperative narcotic requirements, and fewer abdominal incisional wound complications. All of these facilitate a shorter hospitalization.

There is no consensus as to the gestational age beyond which the uterine size would limit the ability to laparoscopically visualize the ductal structures adequately. Contraindications to laparoscopic cholecystectomy in pregnancy include advance cholecystitis, sepsis, ileus, bleeding disorders, pancreatitis, cholangitis, common duct stones, portal hypertension, prior upper abdominal surgery, and an inability to safely introduce a trocar into the peritoneal cavity. With increasing experience, new skills, and improved equipment, surgeons can perform laparoscopic cholecystectomy on selected pregnant patients. The skills required are a combination of traditional dexterity plus special laparoscopic training. This technique requires an adjustment to a 2-dimensional rather than a 3-dimensional coordination with no tactile feedback. Although the operative time is somewhat longer laparoscopic cholecystectomy, the improved morbidity and mortality statistics and the lowered overall cost are significant factors in our recommending this technique for gallbladder surgery in certain pregnant patients with acute cholecystitis.

Summary

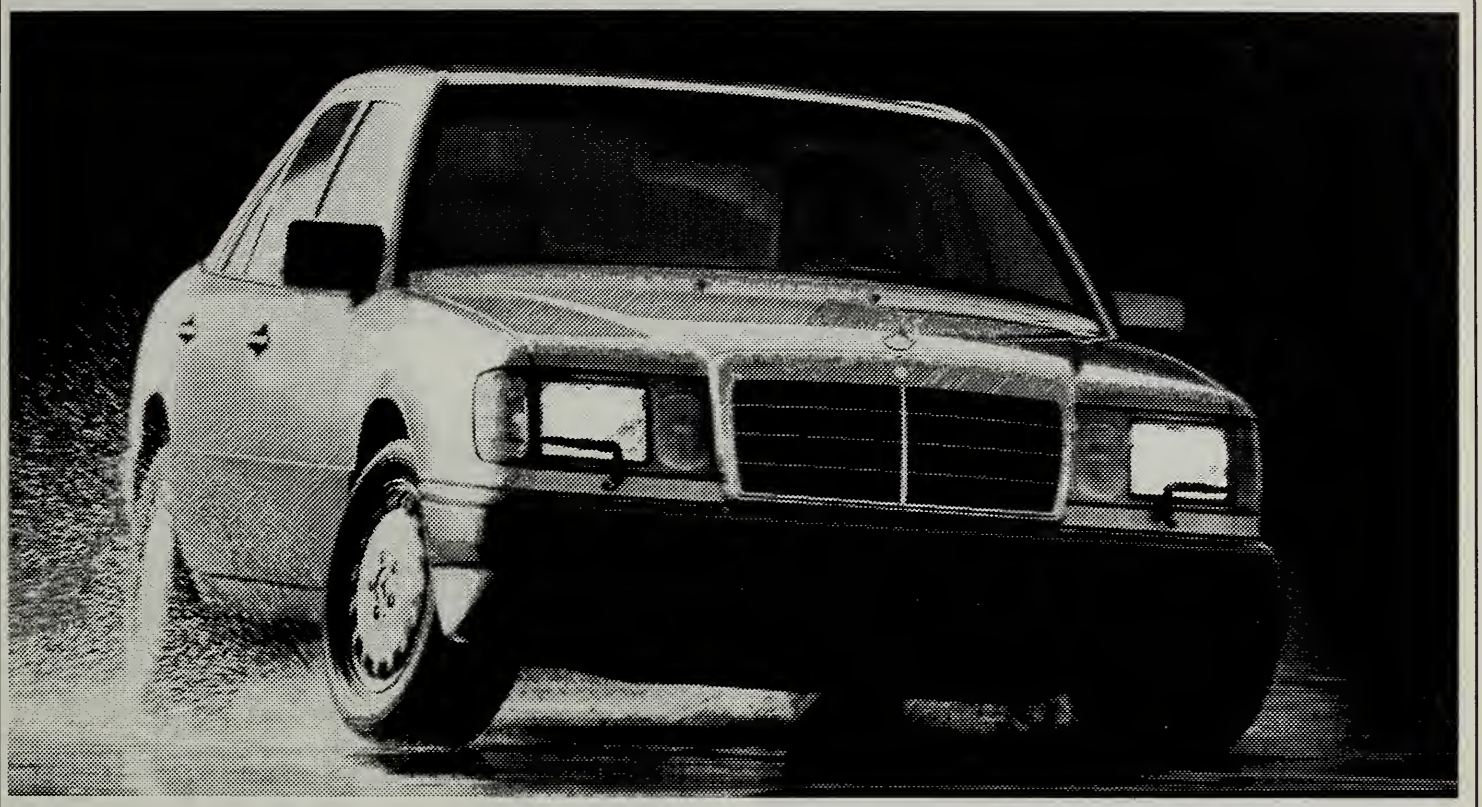
Our case and many other similar cases demonstrates the laparoscopic cholecystectomy can safely be done in pregnant patients who are suitable candidates. Pregnancy should no longer be considered an absolute contraindication to this procedure. Certain guidelines are suggested, however, for the timing of cholecystectomy in pregnancy.

1. The treatment in the first trimester should be conservative with an attempt to delay surgery into the second trimester.
2. Patients in the second trimester can be managed on the initial hospitalization.
3. Patients in the third trimester should be treated conservatively and surgery be delayed if possible until the early postpartum period.
4. The few patients who fail to improve or who worsen with conservative management should have a cholecystectomy regardless of trimester.

As surgical experience and expertise are improved, other previously absolute contraindications may become only relative contraindications to laparoscopic cholecystectomy.

References

1. Gadacz TR, Talamini MA. Traditional versus laparoscopic cholecystectomy. Am J Surg. March 1991;161:336-338.
2. Simons JA. Biliary tract disease and related surgical disorders during pregnancy. Clin Obstet Gynecol. December 1983;26(4):810-820.
3. Block P, Kelly TR. Management of gallstone pancreatitis during pregnancy and the postpartum period.Surg Gynecol Obstet. May 1989;168:426-428.
4. Weber AM, et al. Laparoscopic cholecystectomy during pregnancy. Obstet Gynecol. November 1991;78:958-959.
5. Pucci RO, Seed RW. Case report of laparoscopic cholecystectomy in the third trimester of pregnancy. Am J Obstet Gynecol. August 1991;165:401-2.
6. Hunt MG, et al. Perinatal aspects of abdominal surgery for nonobstetric disease. Am J Perinat. October 1989;6:412-417.■



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High on a pedestal away from reality

Pam Strickland

George was a well-liked, respected young health professional in a small Arkansas town. A happy family man. A deacon in the church. The kind of guy who coached Little League for the fun of it.

But he was plagued by a number of persistent health problems. Finally, at the urging of his friends, he was examined by a local doctor.

The diagnosis was a blood sugar problem. But the treatment didn't work and George's friends urged him to seek another opinion. This time the diagnosis was a possible brain tumor.

It wasn't until he passed out from an overdose of Demerol while on duty that anyone suspected George was an addict.

He had been using every drug he could get his hands on for years. His job had given him access to them.

George is clean now. He spent some time in a Little Rock drug rehabilitation program and hasn't taken any drugs for months. And after a period during which his license was suspended, he is back on the job.

The fact that two doctors misdiagnosed the drug addiction of a fellow health professional isn't unusual, said Dr. Joe Martindale, a Benton family practice physician.

The misdiagnosis comes from doctors who "don't think addicts and alcoholics wear suits or white coats," Martindale said. "There's a denial and a conspiracy of silence that goes on. It's a long time before the individual in trouble is acknowledged."

Martindale should know. By his own account he was high for 12 years. And, he said, "It was real obvious for about the last five."

It began with alcohol, imbibed with the social set. Then he would have a cocktail before dinner. "Then I started taking amphetamines to keep me going during the day. I'd be so high at night, I'd take a sedative to get to sleep. It just became a daily thing, a cycle."

He used samples from the mail.

"While the other doctors read their mail, I was eating mine," he said. Sampling has been severely limited since.

Martindale went clean in 1978 after his wife filed for a legal separation and threatened him with divorce.

They had been in counseling for a year. "I played with it," Martindale admitted in a recent interview. "She learned intervention. She faced me with my problem and made me responsible for my own actions.

"I went to Serenity House for 30 days. It's been a day at a time ever since."

If his wife hadn't stepped in, Martindale believes he would be dead by now. Because, despite his 24-hour high for all those years, not one of his fellow doctors ever said boo to him about it. He never had to go before the state Medical Board.

The townsfolk ignored the problem, too. "When you're a doctor in a small town the police don't write you DWIs, they just take you home."

But Martindale is working to change all that. He knows that 10 to 15 percent of the general population is chemically dependent. Though he doesn't believe the percentages for doctors are higher, he disagrees with others who say the numbers for doctors are lower.

The one-in-eight figure publicized by Dr. G. Douglas Talbott, a nationally-renowned expert on addicted doctors,

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* This article first appeared in *The Arkansas Democrat* on November 4, 1984, and is being reprinted with permission from *The Arkansas Democrat Gazette*.

supports Martindale's theory.

But why would a doctor - or for that matter, a nurse or pharmacist - turn to alcohol or some other drug? Hasn't their training taught them about addiction? Haven't they learned from the addicts they treat?

The reasons aren't any different for a medical professional than they are for the journalist or the bricklayer, according to both Martindale and Dr. Lester Hosto, executive director of the state Board of Pharmacy.

"Stress is the No. 1 reason I see," said Hosto, who for two years has been responsible for overseeing an aggressive rehabilitation program for the state's pharmacists.

"I didn't become an alcoholic because I'm a doctor," Martindale said. "I became an alcoholic because I'm a person who was under stress."

Hosto and Martindale see the medical professional as thinking, "It can't happen to me. I can stop anytime."

Using himself as an example, Martindale said, "I received my M.D.-iety from the University of Arkansas for Medical Sciences in 1957 and I know it all. Until I got rid of that idea, I couldn't get well."

Though, on the one hand, like the electrician or the bookkeeper, doctors have hard days, Martindale believes for doctors it's not that simple.

"You know how it is with your family doctor," he said. "You go to him with a problem and you look at that individual as if he can do no wrong. Everyone treats us that way. They want us to be up on that pedestal and it's very difficult to stay human."

"Every profession has this ego thing," he admits, "but still, I'm not supposed to fail. When I do fail then I'm devastated because God doesn't fail."

But in the past six years he has learned to "recognize my capabilities. I give myself permissions to fail," he explained. "I give myself permission not to know something."

Like so many recovering addicts Martindale has found himself turning more and more of his time and energy to helping other alcoholics and addicts. He has become a licensed alcoholism counselor and serves as a consultant to the Restore program at Riverview Hospital in Little Rock.

He deals with professionals there, serving as both counselor and role model.

"I have an edge over most of them (the counselors). I've been there. It's easier for the patient when they can say, 'OK, my doctor's been through this,'" Martindale said. "I don't sit in judgment. I'm there to help. I can offer the benefit of my experience."

He also works with people individually. "They come to me, usually. We've had some successes. They are recovering or someone else is concerned and tells them, 'Go over to Benton and talk to Joe. He's had some experience with this.'"

Martindale was also instrumental in getting the state Medical Board to set up an Impaired Physicians Committee. The idea was to catch doctors before they reach the bottom, before they get into legal and professional trouble.

"We're not suppose to be some kind of medical SS troops," Martindale said.

Response to the committee has been lukewarm at best. The two-year-old committee, which Martindale serves on, is "still in its infancy," he said, because the board and most of its appointees are still trying to deny the need.

Dr. Joe Verser of Harrisburg, secretary to the board, believes that the three to five physicians who lose their license annually following a public hearing keep the state's remaining 3,350 physicians straight.

"The fact that we have physicians all over the state reading about these drug-related suspensions in the newspapers has done more to control the drug problem among physicians than anything," Verser said in a recent telephone interview.

"They see that and they do everything they can to keep from going through a public suspension. I think they think twice before they do any more drugs."

But Martindale believes a public hearing just "runs 'em underground longer." The real problem, he said, "is that the other 10 percent are out there practicing on you and your friends. They're out there and they're not recovering."

The committee should only address the alcoholism and the drug addiction, Martindale said. "We're not going to address the immorality and the illegality. The board - they're not looking beyond that."

Verser said the doctors who are suspended come to the attention of the board either through law enforcement agencies or referrals from the Pharmacy Board's spot checks on prescriptions.

That is also the way nurse addicts are brought to the attention of the state Nursing Board, said Maxine Otey, director of nursing practice.

Pharmacists are handled in a different manner altogether.

In the cases of doctors and nurses, they are suspended and referred to some type of counseling program. For doctors, there is a specific recommendation; for nurses it's up to the individual.

In both cases they are without their license for at least two years and, sometimes, as long as 10 years.

Mrs. Otey said that in the year ending June 30, 1984, only 28 of the approximately 30,000 individuals licensed by the nursing board lost their licenses because of drug of alcohol related problems.

Though Martindale does not want the Medical Board committee to function exactly like the program Hosto operated for the pharmacists, he does believe that the Pharmacy Board's two-year-old program is doing the job that's needed.

Operating on the theory that addiction is "an occupational hazard to the health professions," the Pharmacy Board has, in a sense, gone looking for pharmacists with problems.

They have found 19 pharmacists. Fifteen of those have

successfully gone through the Restore program and are back on the job.

Basically, if someone suspects a pharmacist has a chemical addiction problem, they tell Hosto. He investigates and if he gets enough evidence, he personally confronts the individual. They are given a choice - surrender their license and go to Restore or take a chance on losing their license at public hearing.

"This is Armageddon," Hosto said. "The biggest fear of an addict is exposure."

Once they are in treatment, Hosto tells them he will work with them to see that they get their license back. At this point in his explanation, Hosto is quick to emphasize that if he has any reason to believe the pharmacist has been putting drugs on the street, he tells the authorities.

"That's a whole new ball game, but a long as they're only giving it to themselves, I don't report it." So far he has reported only two of the 19 pharmacists to police.

Rehabilitation times vary from individual to individual, but when the Restore people say the pharmacist is ready, he can go before the board and ask for his license to be reinstated.

The request is done a public meeting because, Hosto said, "It's not healthy for (them) and not fair to society to pretend that it (their addiction) didn't happen. I wouldn't advise shouting it from a street corner, but family, friends and authorities need to know they're still fighting the battle."

Both Hosto and Martindale said they have found people in the medical community to be very supportive once they know someone with a problem has tried to deal with it.

The board has never reinstated a license against the recommendation of Restore, but, occasionally, they have asked for more information or time, despite a favorable recommendation from Restore.

After the pharmacist's license has been reinstated, he must practice under the supervision of another pharmacist for a determined period of time, which varies, and the supervisor must be approved by Hosto. The addict must also agree to submit to random blood and urine samples for the remainder of his professional life.

So far, all of Hosto's cases have addicts and not alcoholics. He believes this is because of the availability of drugs. Martindale echoes that, adding that it could also be because the drugs don't leave the odor of alcohol. After all, he said, "A drug is a drug is a drug."

Some attempts are being made to better educate health professionals about the dangers of addiction while they are still in school. But Martindale, who has a son in medical school and a daughter in nursing school, doesn't believe it's enough.

Medical students are 35 times more likely to have a drug or alcohol problem than the average person, Martindale said.

To help students become aware of the problems, several plans have been implemented at the university - such as an advocacy program, a seminar warning freshmen students of their high susceptibility to drugs and alcohol, and pharmacy students spending time working with the Restore program.

Hosto describes the look of shock and surprise when a Restore worker spoke to a group of pharmacists. She began her talk by telling them that as long as they believed a drug addict was a 20-year-old high school dropout with long hair and no place to turn or that an alcoholic was only the wino they saw in downtown streets of large cities, "then the guy next to you is going to die because he's an addict and you don't know it."■

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Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

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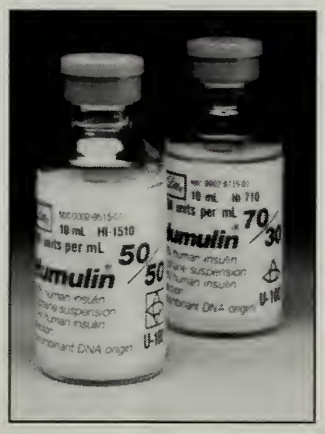

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Racial Minorities at Increased Risk An Arkansas HIV/AIDS Report: Autumn 1992

Source: Arkansas Department of Health

The HIV epidemic in the United States was first recognized as a disease process affecting white homosexuals. Many of the first prevention messages were directed to this subsection of the population and many other persons dismissed the phenomenon as a "gay white male disease."

Now, twelve years down the road, more than one million Americans are HIV infected and no one who puts themselves at risk is immune. The epidemic is upon us.

Public health programs in Arkansas and throughout the nations are monitoring the trends. The disease is moving into heterosexual populations. More women are being infected; more sexually active young people; more minorities. In Arkansas, the most easily recognized trend is the impact upon minorities.

Three programs in particular are measuring the disproportionate impact of the epidemic among racial minorities: (1) HIV infection and AIDS case reporting, (2) HIV screening among applicants for military service, and (3) a blinded seroprevalence study among women of childbearing age.

HIV INFECTION REPORTING

WHITE	20 per 100,000
BLACK	126 per 100,000

Arkansas has reported 2,026 persons infected with HIV; we estimate that another 6,000 to 8,000 may be infected, yet most are unaware of their status. Although minorities compose approximately 17.3 percent of the State's population, minorities now compose approximately 35 percent of reported HIV infections; twice the rate which would be expected if the epidemic were affecting all persons equally.

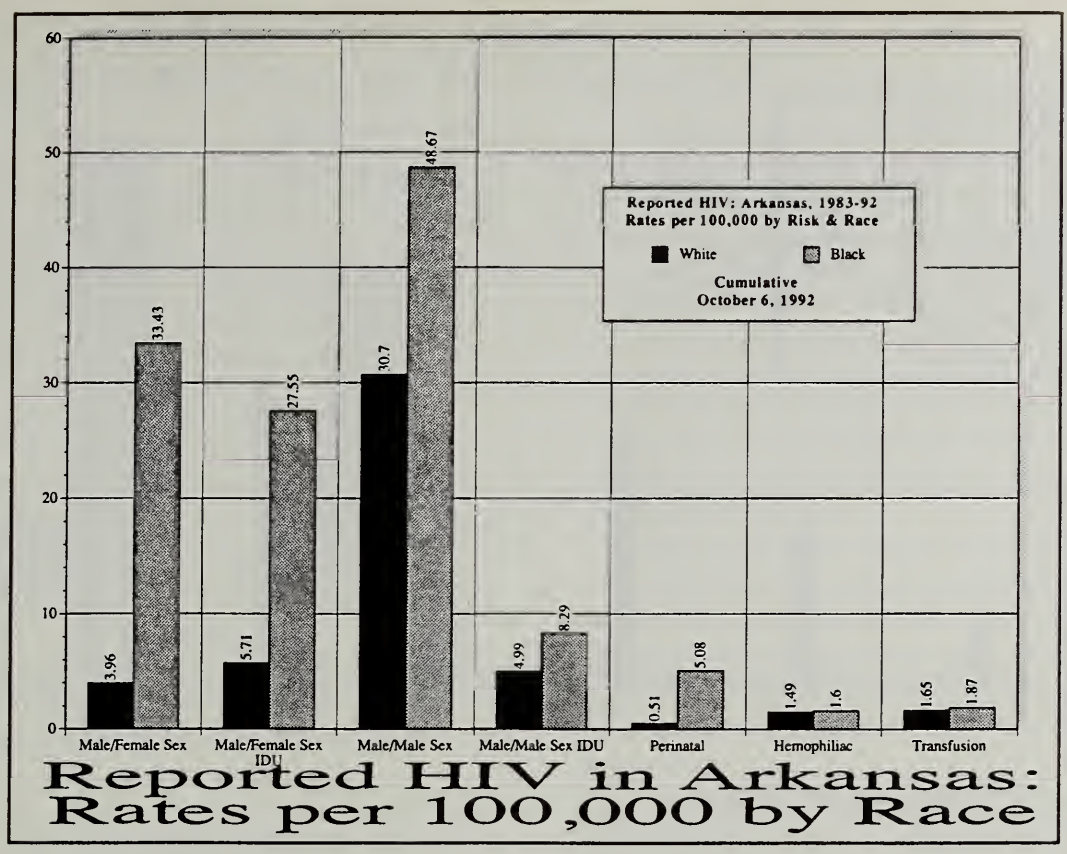
The graph below shows HIV case rates by race and risk per 100,000 population. When looking at rates cumulatively, Arkansas has an HIV case rate of approximately 21.7 per 100,000. The rate, however, varies by race.

Twenty of every hundred thousand white Arkansans have been reported to be HIV+. One hundred twenty six (126) of every hundred thousand black Arkansans have been reported to be HIV+. Blacks are bearing a relative risk about six times that of whites.

These differences in rates do not appear to have been caused by flaws in the reporting system, but rather by differences in behavior. The first graph illustrates that rates between both blacks and whites who were infected by blood products (hemophiliacs and persons receiving blood transfusions) are relatively equal. Infection by blood products was a relatively random event before HIV testing by blood banks was mandated. As a random event, one would expect rates to be nearly equal by race if the reporting system was a true measure. The fact that they are nearly equal indicates that the surveillance system is not flawed for racial data and that other differences in the chart are most likely due to behavioral differences.

In analyzing HIV reporting data by year, race and risk, it becomes evident that at this point in time we are measuring the greatest impact among white homosexuals, black homosexuals, heterosexuals and heterosexual drug users (IDU).

HIV has bridged into the heterosexual population of Arkansas from heterosexual injection drug users. The trends of drug use that fueled the current disproportionate impact of HIV among black Arkansans can be seen in a



similar predictable early stage among white Arkansans.

Figure 2 tracks our knowledge of the epidemic among black Arkansans from 1983 to present. As would be expected, the highest rates of infection have been among persons exposed through male/male sex. Heterosexual injection drug use has also been a leading cause of infection over the past several years. By 1992, however, sexual transmission (heterosexual and homosexual) has begun to dwarf non-sexual transmissions (drug use and other factors).

Figure 3 shows male/male sexual transmission to be the greatest risk, yet rates of transmission in this category may be "topping out." Heterosexual transmission, fueled by infected heterosexual injection drug users, is growing.

FIGURE 2

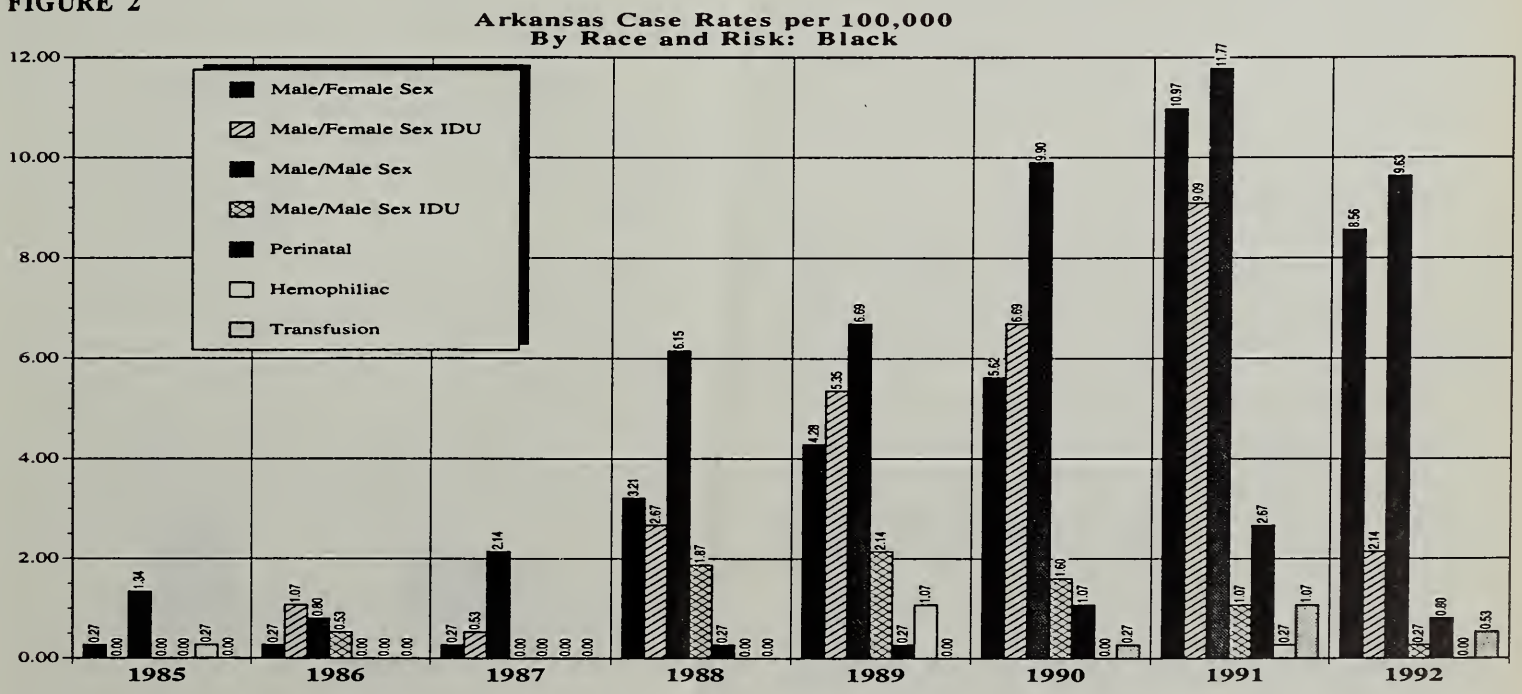
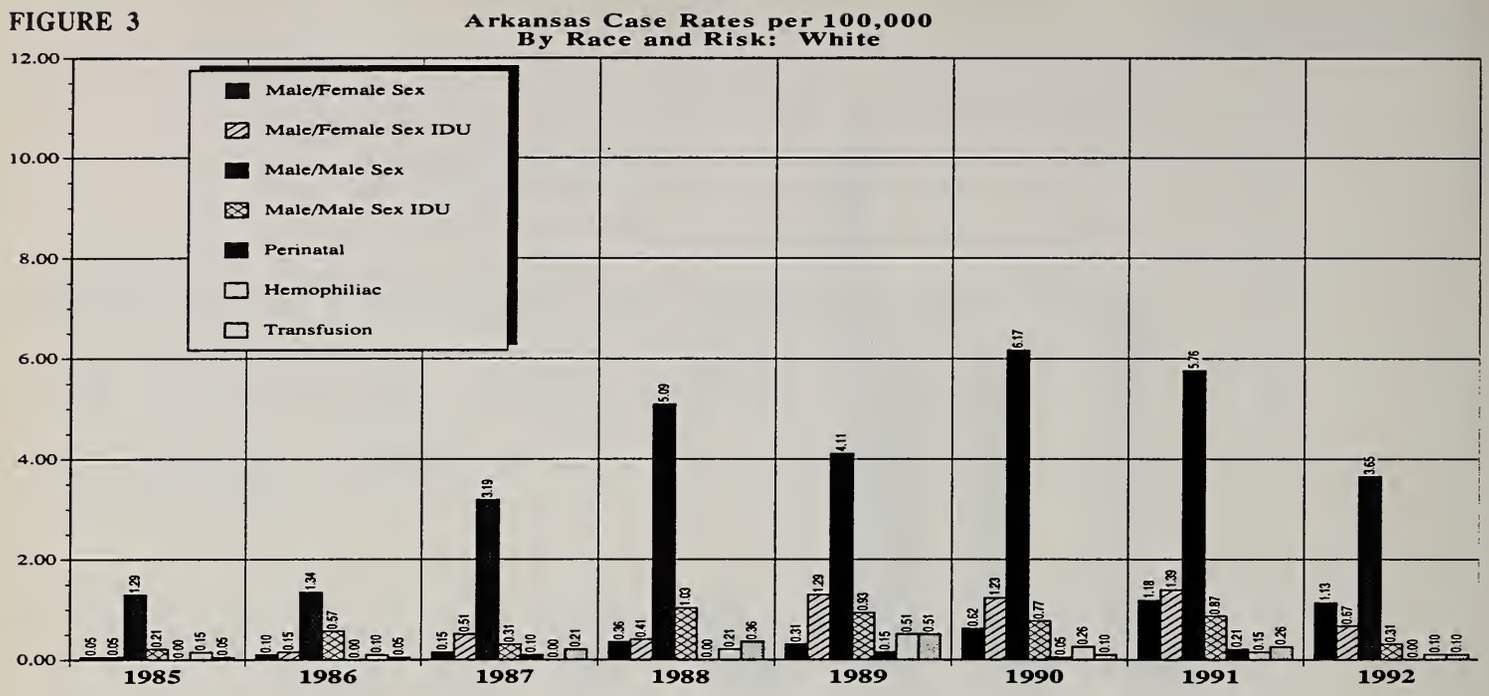


FIGURE 3



There are two other information sources that corroborate the movement of HIV into heterosexual and minority populations.

SURVEY OF MILITARY APPLICANTS

WHITE	33 per 100,000
BLACK	84 per 100,000

Since October 1985, the military has screened all civilian military applicants for HIV. Military applicants are interviewed by recruiting officials about drug use and homosexual activity (both of which are grounds for exclusion from entry into military service) before referral for medical evaluation. Potential applicants are informed that they will be screened for HIV antibody. It is expected, therefore, that IV drug users and homosexual men are underrepresented among military applicants who are medically evaluated.

Although there are probably certain socio-economic differences between military applicants and the population as a whole, the results of the military survey does provide a relatively unbiased look at HIV infection by race and sex.

Since 1985, a total of 53,074 Arkansans have been tested as they have applied for military service. Only 24 have been found to be HIV+ for a rate of .05 percent.

Racially, however, the military data parallels HIV reporting. Averaging the data since 1985, black males had a rate of 87.1 per 100,000; white males had a rate of 34.3. Black females had a rate of 71.5 per 100,000; white females had a rate of 22. Overall, black males had a relative risk about 2.6 times that of white males and black females had a risk 3.5 times that of white females.

Over time, however, the differences become more pronounced. In Arkansas, rates are increasing among black military applicants while decreasing among white applicants (Figure 4). In the last three years, rates among blacks have increased by 45 percent while decreasing by 67 percent among whites.

Nationally, 3,860 persons have tested positive out of a total of more than three and a half million applicants for an overall rate of 103 per 100,000. The rate at the national level also varies by race (Figure 5). Although the rates are

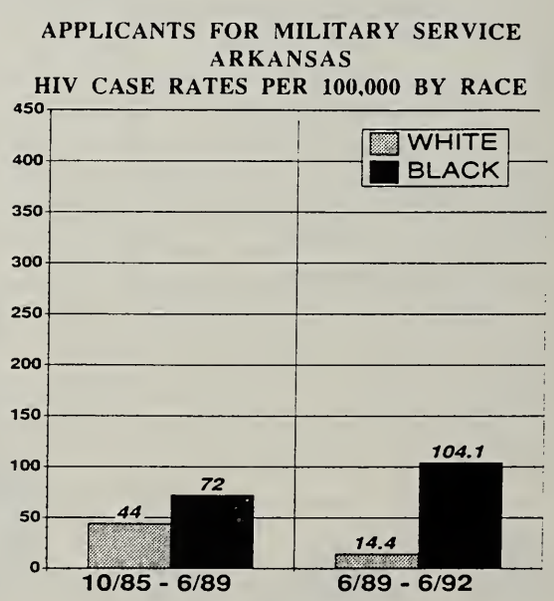


FIGURE 4

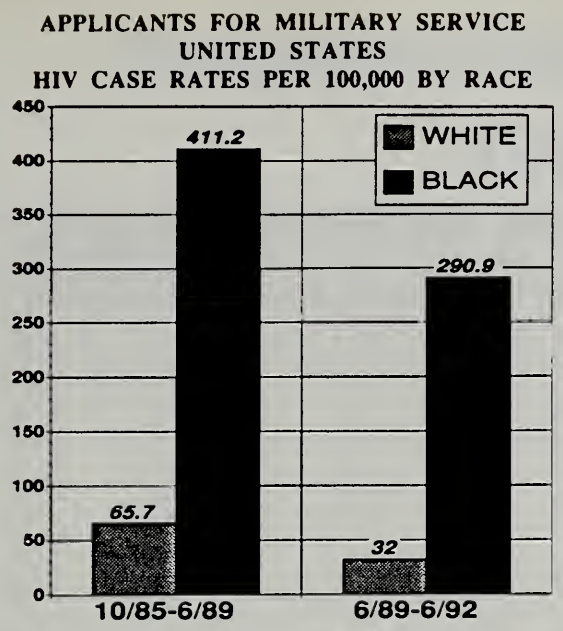


FIGURE 5

much higher nationally than in Arkansas, the national rates are declining among both white applicants and black applicants.

SURVEY OF CHILDBEARING WOMEN

WHITE	33 per 100,000
BLACK	84 per 100,000

Since July of 1989, the Department of Health has been testing leftover blood specimens form all newborns in a blinded manner to monitor the extent at which HIV is entering the heterosexual population. The survey is particularly helpful in measuring HIV in a complete cross-section of a population (e.g. women who give birth). In 1991, the survey tested specimens from 99.6% of all live births registered in Arkansas.

In order to prevent an infringement of privacy, any information that might be used to later trace identity and link HIV result is destroyed prior to testing. However, some demographic information is maintained.

Through July 1992, we have tested 102,982 specimens and found 47 to be positive for HIV. *{Note: Infants born to an HIV positive mother will test positive for the mother's antibodies at birth; however, only one-third of those infants will go on to develop HIV themselves.}*

The overall HIV rate among childbearing women in Arkansas is 46 per 100,000, although this too varies by race. Among white childbearing women, 20 of every 100,000 are HIV infected; while among non-white childbearing women, this rate is 126 per 100,000.

The differences by race are even greater when viewed by area of residence. In 1991, 1 of every 400 non-white childbearing women in south Arkansas tested positive for HIV.

Although these rates continue to show the disproportionate impact of HIV by race, the rates have been relatively stable, showing no noticeable increase over the past three years.

SUMMARY

The demographics of the HIV epidemic continue to change. Rates among white homosexuals seem to be leveling off; but there does not appear to be a corresponding decline among black homosexuals.

Additionally, having found its first foothold among heterosexual injection drug users, increases in reported infection can be seen among heterosexuals who engage in non-monogamous, unprotected sex. To date, this increase in heterosexual transmission has been more pronounced among black Arkansans than white Arkansans. However, there are definite growth trends among heterosexuals regardless of race.

Individuals who engage in risky behavior, specifically injection drug use, unprotected sex, and sex with multiple sex partners, should now consider that the risk of contracting HIV increases daily. Persons who engage in such risky behavior should educate themselves on the transmission of HIV and attempt to minimize their chances of infection.

Persons who believe that they may be at risk for HIV should seek immediate testing and treatment. Confidential testing is provided by the Department of Health and individuals may call local offices for times that testing is available.

NOTE: All headlined figures in this article relate to cumulative HIV prevalence in Arkansas. For uniformity, all rates have been adjusted to express as number of cases per 100,000 population as based on the 1990 census.

It should be noted in reviewing all graphs related to this article that 1992 statistics are only valid through September and numbers will continue to grow throughout the remainder of the year.■

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Arkansas HIV/AIDS Report 1983-1992

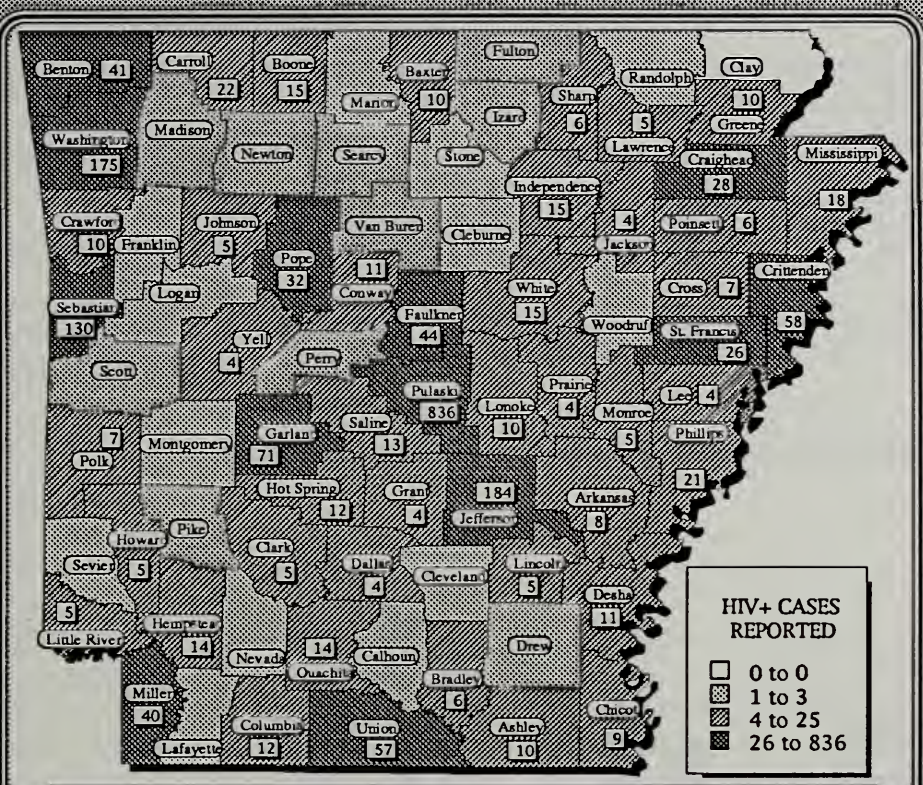
Arkansas: 1983 through November 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	437	421	385	1,810	85.42
	Female	1	1	6	27	39	72	89	74	309	14.58
AGE	< 5	0	0	1	1	2	9	14	5	32	1.51
	5-12	0	0	0	1	1	5	2	0	9	0.42
	13-19	0	0	0	8	8	14	20	24	74	3.49
	20-29	8	10	15	109	125	192	154	153	766	36.15
	30-39	7	15	22	86	105	206	219	177	837	39.50
	40-49	4	7	11	24	35	62	74	65	282	13.31
	> 49	1	1	6	6	12	19	23	33	101	4.77
	Unknown	0	0	0	8	2	2	4	2	18	0.85
RACE	White	16	24	47	171	178	353	312	284	1,385	65.36
	Black	4	9	8	70	107	153	195	165	711	33.55
	Other	0	0	0	2	5	3	3	10	23	1.09
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	459	2,119	100%

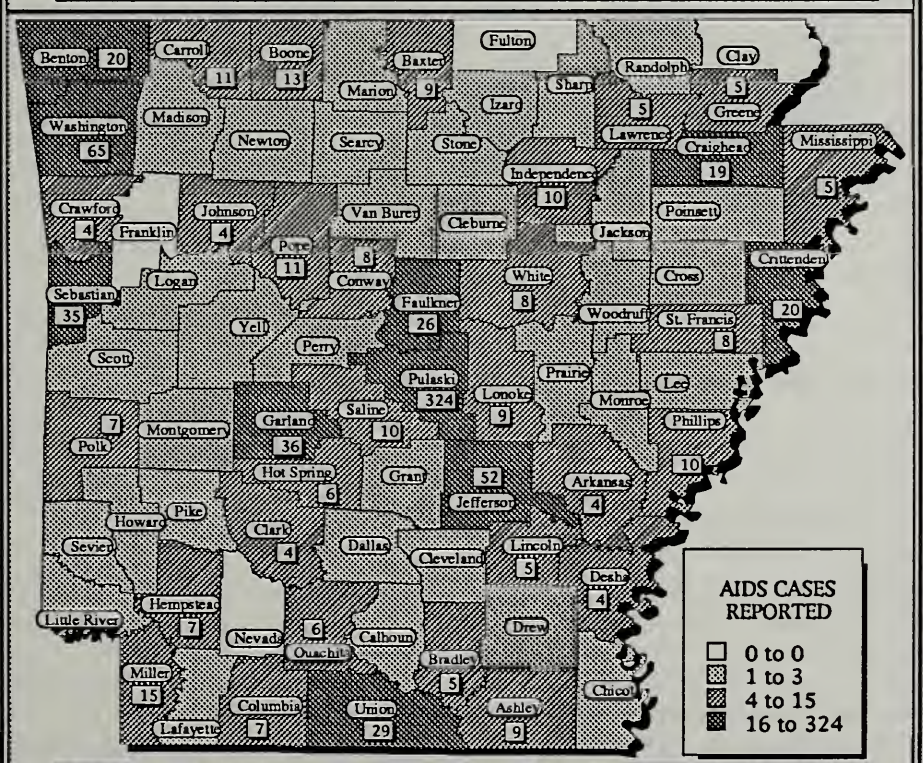
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	228	806	89.06
	Female	1	0	4	6	10	20	25	33	99	10.94
AGE	< 5	0	0	0	1	1	6	6	2	16	1.77
	5-12	0	0	0	1	0	1	1	0	3	0.33
	13-19	0	0	0	0	0	4	3	2	9	0.99
	20-29	7	9	15	27	24	55	57	73	267	29.50
	30-39	3	13	23	36	41	78	80	117	391	43.20
	40-49	1	6	8	10	7	35	41	49	157	17.35
	> 49	1	0	4	8	7	11	13	18	62	6.85
RACE	White	9	22	43	61	58	141	134	191	659	72.82
	Black	3	6	7	20	21	47	66	67	237	26.19
	Other	0	0	0	2	1	2	1	3	9	0.99
RISK	Male/Male Sex	7	17	31	59	50	118	118	155	555	61.33
	Injection Drug User (IDU)	0	2	10	4	11	18	28	32	105	11.60
	Male/Male Sex & IDU	3	9	4	6	6	18	17	16	79	8.73
	Heterosexual	2	0	2	3	6	10	10	19	52	5.75
	Transfusion	0	0	2	7	3	7	11	3	33	3.65
	Perinatal	0	0	0	1	1	6	6	2	16	1.77
	Hemophiliac	0	0	0	1	1	5	5	4	16	1.77
	Undetermined	0	0	1	2	2	8	6	29	48	5.30
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	261	905	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



County of residence at the time of test for the 2,119 Arkansans reported to be HIV+. (11/25/92)



Of the 2,119 Arkansans reported to be HIV+, 905 have been diagnosed with AIDS. (11/25/92)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

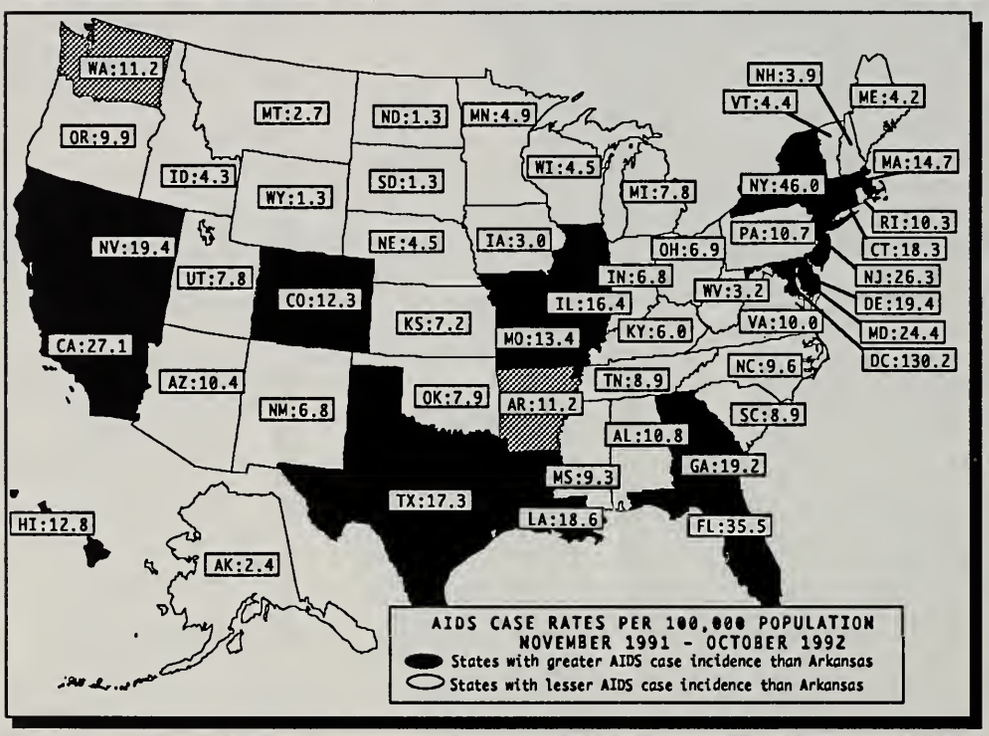
(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992

	Arkansas	United States
Total AIDS Cases Reported, previous 12 months	264	47,457
AIDS Case Rate per 100,000 population	11.2	18.4
Cumulative AIDS Case Reports: 1983 - PRESENT*	905	230,179
Adult	886	226,281
Pediatric	19	3,898
Deaths: 1983 - PRESENT*	462	152,153
Adult	455	150,114
Pediatric	7	2,039
Mortality Rate	51.0%	66.1%



	Arkansas	United States
Men who have sex with men	61.3%	56.8%
Heterosexuals who use Injected Drugs	11.6%	22.4%
Men who have sex with men and use Injected Drugs	8.7%	6.3%
Heterosexual contact with a person at risk	5.8%	6.1%
Transfusion with blood products	3.7%	2.2%
Infants born to HIV-infected mothers	1.8%	1.4%
Persons with hemophilia	1.8%	0.9%
Risk unknown at this time	5.3%	3.9%

** Arkansas statistics are valid through November 25, 1992; United States statistics are valid through September 1992; case rates have been calculated for the period November 1991 - October 1992.*

CASE RATES PER 100,000	
DC	130.2
NY	46.0
FL	35.5
CA	27.1
NJ	26.3
MD	24.4
DE	19.4
NV	19.4
GA	19.2
LA	18.6
CT	18.3
TX	17.3
IL	16.4
MA	14.7
MO	13.4
HI	12.8
CO	12.3
AR	**11.2**
WA	11.2
AL	10.8
PA	10.7
AZ	10.4
RI	10.3
VA	10.0
OR	9.9
NC	9.6
MS	9.3
SC	8.9
TN	8.9
OK	7.9
MI	7.8
UT	7.8
KS	7.2
OH	6.9
IN	6.8
NM	6.8
KY	6.0
MN	4.9
NE	4.5
WI	4.5
VT	4.4
ID	4.3
ME	4.2
NH	3.9
WV	3.2
IA	3.0
MT	2.7
AK	2.4
ND	1.3
SD	1.3
WY	1.3

Source: AIDS Surveillance Unit, Arkansas Department of Health.

As Society Struggles with a Fault-Based Malpractice System, Responsible Parties Encourage Tort Reform-But only with Input and Support from the Medical Community

Robert J. Miller*

Occasionally, medical or dental treatment results in unsatisfactory outcomes for patients. There are no guarantees that babies will be born perfect, that patients will be hardy enough to withstand the rigors of surgery, that diseases can be easily diagnosed and totally cured. A sponge remains undetected, even under the careful eye of the most highly-skilled surgeon, the patient reacts to a medication, and Murphy's Law prevails.

Out of this group of individuals a few suffer because actual negligence marred their care. The ethical physician will do everything possible to make things right, regardless of whether the damage was caused by an unkind act of nature or by human error.

Society is now in a better position, both sociologically and technologically, to classify patient injuries. And this ability, coupled with the American fault-based legal system, has exacerbated the malpractice battles waged throughout the nation's courtrooms.

Americans are on the brink of asking if the crucial issue in dealing with an injured party is not "Who's to blame?" but "What kind of support and care does this patient need?" Separation of these two antagonistic, but nonetheless important, issues would provide several benefits.

First, injured parties might be much more quickly assessed and compensated. The accrual and implementation of knowledge acquired from the study of injuries would benefit all health care as well as injured parties.

Second, with the removal of a lynching motive, health care professionals could more easily identify and further educate those within their ranks who have indeed caused injuries. Without the crushing penalties of lost reputation and financial ruin, health care professionals could be more open when mistakes do occur.

Perhaps some might even step forward to volunteer information about flawed outcomes so that others might benefit from their experiences. Within the constricts of this goal, disciplinary action would be but one option, not a requirement.

Ultimately, the courts and those entrusted to establish laws must take direction from citizens in deciding an honorable means of aiding those who suffer health care-related injuries. Society at large will benefit as "deep pocket" awards are eliminated and adequate care is provided for those who truly require it.

The current system errs whenever it gives money to injured parties if there has been no negligence. Some injured parties have been denied recourse because they were unappealing to juries or poorly represented. And it is also true that doctors who have committed shocking acts of negligence have walked away, clean, because they made credible witnesses on their own behalf and had excellent legal counsel.

It is not uncommon that plantiffs sustaining negligible injuries have been awarded millions while some parties who have suffered catastrophic losses receive pittances. Emotion and logic lock horns during jury deliberations-and justice has not always won. The best plan for resolving the dilemma will ultimately provide relief for *both* sides.

And, in the meantime, this one fact remains, whether plaintiffs receive just compensation, or indeed any compensation at all, it is not the responsibility of reputable professional liability insurers to decide. As long as the antagonistic legal means of resolving such issues continues to exist, the honor-

* Mr. Miller is Vice President of Consumer Affairs and Risk Management for The Medical Protective Company.

able insurer has but one goal: the legal protection of its insured doctors. Monies paid in premiums should always be reserved to assure that adequate defense funding will be available and that the least amount is spent resolving disputes while, at the same time, protecting the interests of the insureds.

As the nation's oldest professional liability insurer, The Medical Protective Company has a long and honorable history of involvement, both on national and state levels, in attempts to defuse the vitriolic nature of the malpractice system. Time and again, we have participated in discussions, testified before legislatures, advised courts, and conferred with experts (on both sides of the issue) in honest efforts to improve the situation. We have opened our massive records department to the interests of malpractice research and we have engaged in nearly a century of risk management education in order to protect doctors from the pitfalls our experience spotlights.

Doctor, you can help protect yourself and your profession. Become informed and involve yourself in issues that will affect you and your successors into the next century. Voice your concerns to your state legislators. Utilize your state and local medical societies to present your recommendations. The opinions of a group of doctors will carry greater weight than those of any individual lobbyist, including outside entities such as well-intentioned insurers. With the beginning of a new administration in Washington, this is an ideal time for physicians to provide input on such crucial matters as tort reform and, indeed, on the entire health care system.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

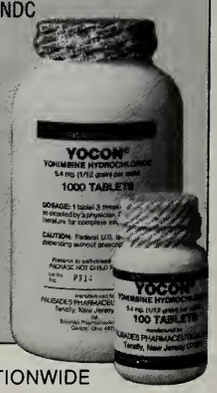
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Probable 1993 State Legislative Proposals

Charles Rodgers, M.D.
Chairman, Governmental Affairs Council

Introduction

January 11, 1993, marks the beginning of the 79th Session of the Arkansas General Assembly. Each year, more and more medical-related issues are being considered by the Arkansas legislature...issues that have tremendous impact on patient care, clinic administration and physician reimbursement.

This is a brief recap of the anticipated issues of interest to the physicians of Arkansas. Certainly there will be others and a possibility that some of these issues might not surface. Because medical issues are often complex, it is imperative that AMS members familiarize themselves with the issues and discuss them with their local legislators.

AMS members are also urged to read the weekly legislative updates and respond to requests for legislator contact. Amendments to proposed bills can completely change the intent of legislative issues, and it is important for physicians to keep up-to-date on the progress of Governmental Affairs by calling 1-800-542-1058 or 224-8967 in Little Rock.

Abortion

The Arkansas Medical Society has the following position on the issue of abortion: the Society reaffirms that (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practices Act; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgement. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Civil Immunity for Physicians Reporting Drug Abusers

Physicians are currently prohibited by patient confidentiality rules from reporting patients, particularly walk-ins, that are doctor shopping for the purpose of obtaining drugs. The Arkansas Medical Society will support legislation that protects physicians in the reporting of suspected drug abusers.

Civil Immunity for Reporting of Impaired Physicians

There is a reluctance on the part of many physicians to report a fellow physician that they know or suspect may be drug or alcohol impaired. Part of this reluctance is based on the fear of later liability. This bill would grant immunity to those persons who report impaired physicians to an organized committee such as the Arkansas Medical Society Physicians' Health Committee.

Civil Immunity for Treatment of Indigent Patients

In the 1989 and 1991 legislative sessions, the Arkansas Medical Society supported a bill that granted civil immunity to physicians who treat patients under an indigent health care program. This bill, which unanimously passed the House and the Senate, was vetoed by Governor Clinton in 1989. In 1991, it passed the House but failed in the Senate committee.

Drivers License Eye Exams

The AMS supports the efforts of the opthalmologists and optometrists to allow certain drivers with sight defi-

ciencies the ability to drive under restricted conditions. This limited driving ability would be allowed only after certification by an eye-care professional.

Expanded Practice by Limited Licensed Practitioners

The Arkansas Medical Society is concerned with efforts that would increase the scope of practice of limited licensed practitioners.

Arkansas physicians are opposed to physical therapists providing direct care without a physician's referral. Because many health problems mimic others, they should only be treated by physical therapists after a physician has diagnosed the problem. Also, adding another direct provider to be reimbursed by health insurance would cause an additional drain on an already over burdened and expensive system.

The medical technologists are exploring legislation which would require a certified medical technologist in every physician's office. Such legislation would remove the physician's authority to appoint office personnel to fulfill these key positions and would place a burden on rural physicians due to the shortage of certified medical technologist in our state.

The social workers have traditionally introduced a bill that mandates insurance coverage for treatment of their clients. Past proposals have included reimbursement at the same levels as psychiatrists. The Arkansas Medical Society is opposed to this because of the social workers limited training and the added cost to the health care system.

The Arkansas Medical Society will oppose efforts by nurse practitioners to expand their scope of activity to include the independent prescribing of drugs.

Incentives for Rural Physician Practice

The Arkansas Medical Society will support legislative efforts to increase the incentives for rural medical practice through loan forgiveness programs, tax incentives, and more dollars for student loan programs.

Increased Physician Participation in the Delivery of Babies

Primarily due to the high cost of medical malpractice insurance, there are currently 27 counties in Arkansas where there are no physicians delivering babies. The Arkansas Medical Society will join with the Arkansas Department of Health in supporting legislation that will help increase the number physicians treating pregnant mothers and delivering babies. We will support civil immunity laws for the treatment of obstetrical cases and any efforts by the state to reimburse physicians for their malpractice insurance premiums.

Insurance Reform

In the area of insurance reform, the Arkansas Medical Society is currently reviewing several proposals regarding payment by third party payors. One proposal will require third party payors to notify the physician when the insurance payment has been paid to the patient. Another proposal being considered would require co-signatures of the provider and the patient before a third party payor check or draft could be cashed.

The Arkansas Medical Society will also support a "Third Party Payor Responsibility Act". Many physicians spend a great deal of their time receiving permission or responding to questions from nurses or medical directors of utilization review organizations. These questions range from pre-admission certification to prior approval before the physician may extend a patient's hospital stay. This act would not alter their policies, however, if a patient should be harmed as a result of the utilization review organization's decision, the third party payors can be held liable.

Legal Reform

The Arkansas Medical Society anticipates and will oppose efforts by the plaintiffs attorneys to create a statute which establishes prejudgment interests for law suits yet to be litigated. The AMS also opposes changing the Arkansas Comparative Fault Law which has served the citizens of this state fairly for many years. Experience in other states indicates an increase in medical malpractice premiums of up to 50% if such legislation is adopted.

Life Support and Living Wills

With the increased nationwide awareness of living wills and withdrawal of life support systems, the Arkansas Medical Society will work closely with the Arkansas Bar Association to review and improve the current Arkansas statutes.

Mandatory Assignment

There is discussion by several senior citizen groups of legislation which would require physicians to accept mandatory assignment of Medicare as payment in full in order to maintain licensure. Arkansas physicians are opposed to this concept because it would create a two-tiered health care system in the state. Also, the inability to balance bill those patients who can afford to pay would result in cost shifting to those private pay patients and those covered by employee benefit plans. Arkansas physicians have always dicounted fees on the bases of need, not on the bases of age. Currently, 54% of the physicians in Arkansas accept Medicare as payment in full. Eighty percent of all eligible claims are accepted as payment in full. The inability of Arkansas physicians to balance bill would likely result in fewer physicians available to treat Arkansas' elderly citizens.

Medicaid Reform

The AMS pledges to work with the General Assembly in correcting many of the problems inherent in the Department of Human Services. The AMS supports efforts to limit

bureaucratic administrative problems; fund the program to allow reasonable reimbursement for Medicaid providers; and work toward a goal of expanded access to quality care for all Medicaid recipients.

Medicaid Prescription Drug Program

The Arkansas Medical Society is generally opposed to a Prior Approval Program for the prescribing of prescription drugs for Medicaid patients. There is a danger of delay in treatment; adverse treatment in the substitution of drugs; and increased hospitalization when medical decisions are being made by third-party non-physicians who have never seen the patient.

Medical Records

The AMS opposes legislation that would not allow a reasonable charge for the providing of and retrieval of medical records requested by patients, attorneys, and third-party payors.

Medical Waste

AMS members are required by OSHA and other agencies to safely dispose of medical waste and discarded needles, etc. The Arkansas Medical Society supports the rights of local physicians in cooperation with local hospitals to dispose of this waste in local medical waste facilities, without the dangers of contracting with medical waste haulers who often charge exorbitant fees.

Prohibition of Bottle Rockets

Due to an alarming increase in the number of injuries to the eye, the AMS supports the ophtalmologist who will encourage legislation banning the sale of bottle rockets.

Public Health Risks

The Arkansas Department of Health will consider legislation further regulating the practices of tatooing, ear piercing, and certain aspects of cosmetology. The AMS shares their concern for possible risks of blood-borne disease and the need for close scrutiny.

Safety Issues

In an effort to curtail the tragedy of highway accidents from both a medical and economic impact, the AMS will again be involved in a safety coalition that will continue to oppose a repeal of the current Arkansas Motorcycle Helmet Law.

Tanning Facility Regulations

The use of tanning facilities has resulted in increased incidents of skin cancer and adverse medical reactions for persons using certain medications. The Arkansas Medical Society will propose legislation which regulates tanning facilities and requires disclosure, both written and posted, warning of the dangers of using certain tanning devices.

Triplicate Prescriptions

The Arkansas Medical Society will oppose any efforts to establish a triplicate prescription program for Schedule II drugs. We feel that this is government overkill and would penalize the 99% of the physicians who are trying to practice good medicine in an effort to punish the 1% of the abusers. A triplicate prescription program, which would require physicians to fill out prescriptions on sequentially numbered pads and a copy of each prescription to be mailed to a government depository, would result in additional cost, additional adminstrative burdens, and possible violations of patient confidentiality.

Uninsurable Risk Pool

The Arkansas Medical Society, the Arkansas Hospital Association, and a coalition of health insurance representative have developed legislation establishing an uninsurable risk pool. This pool will provide insurance coverage for those persons who have been denied insurance due to pre-existing conditions or other disqualifying factors. Persons eligible for the risk pool will purchase coverage at a cost of approximately 150% of the highest standard market price. Additional funding will be proposed either through a cigarette tax or an income tax surcharge.

Workers' Compensation

The AMS has worked diligently to address the growing cost and accessiblity problems of workers' compensation insurance. We have developed a fee schedule in cooperation with the Workers' Compensation Commission, labor, and management which should result in significant savings. We urge legislators to give this new payment system a chance to work before enacting more restrictive reforms.■

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Minutes of the House of Delegates of the Arkansas Medical Society November 22, 1992

Speaker of the House John Crenshaw called the House of Delegates to order at 11:30 a.m., Sunday, November 22, 1992. Member of the House seated were:

Officers:
President - Larry Lawson, Green/Clay County
President-elect - Glen Baker, Pulaski County
Speaker of the House - John Crenshaw, Jefferson County
Vice Speaker of the House - Brenda Powell, Garland County
Secretary - Charles Rodgers, Pulaski County
Treasurer - Lloyd Langston, Jefferson County

Past Presidents:
John Burge, Chicot County
C. Randolph Ellis, Hot Springs County
John Hestir, Arkansas County
Ray Jouett, Pulaski County
Payton Kolb, Pulaski County
Ben Saltzman, Baxter County
Joe Verser, Craighead/Poinsett County
George Warren, Union County

Councilors:
District 1 - Merrill Osborne, Mississippi County; Dwight Williams, Greene/Clay County
District 2 - Lloyd Bess, Independence County; Michael Moody, Tri-County
District 3 - Samuel McGuire, St. Francis County; Hoy Speer, Arkansas County
District 4 - Anna Ridling, Jefferson County; Paul Wallick, Drew County
District 5 - Robert Nunnally, Ouachita County
District 6 - James Armstrong, Little River County; F.E. Joyce, Miller County
District 7 - Ronald Bracken, Garland County
District 8 - Joseph Beck, Paul Cornell, William Jones, Charles Logan, Jerry Mann, and Harold Purdy, Pulaski County
District 9 - Robert Langston, Boone County; David Rogers and Janet Titus, Washington County
District 10 - Gerald Stolz, Pope County; Morton Wilson, Sebastian County

Delegates:
Ashley County - C.E. Ripley
Baxter County - Robert Baker
Boone County - Carlton Chambers
Craighead/Poinsett County - Joe H. Stallings
Crittenden County - G. Edward Bryant
Greene/Clay County - Roger Cagle
Jackson County - John Ashley
Jefferson County - Anna Ridling
Miller County - Joseph Robbins
Polk County - David Fried
Pope County - James Kolb
Pulaski County - Raymond Biondo, Amail Chudy, Fred Henker, Anthony Johnson, J. Mayne Parker, Frank Sipes, John Redman
Van Buren County - John Hall
White County - Dan Davidson

The following business was transacted

1. Approved the Arkansas Medical Society Auxiliary's request to change their name from the Arkansas Medical Society Auxiliary to the Arkansas Medical Society Alliance. This name change is keeping with the precedent set by the American Medical Association Auxiliary who voted in July to change their name to the American Medical Association Alliance.
2. Lynn Zeno, Director of Governmental Affairs, introduced the featured speaker, Sentator Mike Beebe of Searcy. Senator Beebe discussed proposed legislation for the 1993 General Assembly.
3. Lynn Zeno discussed 1993 legislation as proposed by the Governmental Affairs Council.
4. Dr. James Armstron, Chairman of the Board of Directors of the Arkansas Foundation for Medical Care, reported on the activities of the PRO.

The House adjourned until April 15, 1993.

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New Members

ARKANSAS COUNTY

Tracy, Wallace L., Family Practice, Dewitt. Born January 21, 1955, Little Rock. Medical education, UAMS, 1987. Internship/Residency, AHEC Pine Bluff, 1990. Practice experience, 2 years. Board certified.

CRAIGHEAD COUNTY

Stubblefield, Sandra C., Family Practice, Brookland. Born December 21, 1959, Jonesboro. Medical education, UAMS, 1988. Internship/Residency, AHEC Northeast, Jonesboro, 1991. Practice experience, 1 year. Board certified.

Stubblefield, W. Scott, Family Practice, Brookland. Born June 6, 1960, Blytheville. Medical education, UAMS, 1987. Internship/Residency, AHEC Northeast, Jonesboro, 1990. Practice expreience, 2 years. Board certified.

FAULKNER COUNTY

Clark, Robert L., General Surgery, Conway. Born October 23, 1958, Little Rock. Medical education, UAMS, 1985. Internship, UAMS, 1986. Residency, Des Moines VA Medical Center, Des Moines, IA, 1991. Practice experience, 1 year. Pending certification.

POLK COUNTY

Sosa, Humberto J., Cardiology, Mena. Born June 18, 1934, Mexico. Medical education, Universidad de Michoacan, Morelia, Michoacan, Mexico, 1961. Internship, Kern General, Bakersfield, CA, 1972. Residency, Long Beach Memorial, Long Beach, CA, 1974. Practice experience, 16 years. Board eligible.

PULASKI COUNTY

Bushman, Gerald A., Anesthesiology, Little Rock. Born July 10, 1955, Dallas, TX. Medical education, UAMS, 1981. Internship, UAMS, 1982. Residency, UAMS, and Duke University, Durham, NC, 1985. Practice experience, 8 years. Board certified.

Shah, Hemendra R., Diagnostic Radiology, Little Rock. Born November 25, 1945, Ahmedabad, India. Medical education, BJ Medical School, Ahmedahad, India, 1970. Internship, Bronx Lebanon Medical Center, NY, 1977. Residency, Newark Beth Israel Medical Center, NJ, 1987. Board certified.

SEBASTIAN COUNTY

Cesar, Luis G., Neurosurgery, Fort Smith. Born November, 12, 1946, Itatinga, SP, Brazil. Medical education, Unirio-RJ, Rio de Janeiro, RJ, Brazil, 1971. Internship, University of Minnesota, MN, 1973. Residency, Rush University, Chicago, IL, 1978. Practice experience, 14 years. Board certified.

Linzman, Rod F., General Practice, Fort Smith. Born December 16, 1957, Hugo, OK. Medical education, Oklahoma State University, Tulsa, OK, 1981. Internship, Hillcrest Health Center, 1982.

Wright, Charles K., Family Practice, Fort Smith. Born November 15, 1956, Little Rock. Medical education, UAMS, 1989. Residency, AHEC Fort Smith, 1992. Board eligible.

WASHINGTON COUNTY

Grear, Danna F., Diagnositc Radiology, Fayetteville. Born May 31, 1959, Rolla, MO. Medical education, Universtiy of Texas Medical Branch, Galveston, TX, 1985. Internship/Residency, UTMB, 1989. Board certified.

Stagg, Stephen W., Gastroenterology, Springdale. Born March, 7, 1960, Eunice, LA. Medical education, Loui7siana State University, New Orleans, LA, 1985. Internship/Residency, University of Texas Medical Branch, Galveston, TX, 1988. Fellowship, gastroenterology, University of Tennessee, Memphis, TN, 1990. Practice experience, 2 years. Board certified.

RESIDENTS

Araneda, Erick P., Internal Medicine, Born October 21, 1965, Guatemala, Mexico. Medical education, University Francisco Marroquin, Guatemala, Mexico, 1991. Internship/Residency, UAMS.

Authement, Chris A., Emergency Medicine. Born April 8, 1963, Houston, TX. Medical education, Louisiana State University Medical College, New Orleans, LA, 1990. Residency, UAMS.

Beck, William A., Anesthesia. Born September 6, 1962, Beaver, PA. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1990. Internship, St. Joseph' Medical Center, South Bend, IN. Residency, UAMS.

Caldwell, Williams E., Opthalmology. Born April 12, 1962, Greenville, SC. Medical education, Medical University of South Carolina, Charleston, SC, 1988. Internship/Residency, UAMS.

Chen, Fen Y., Pathology. Born March 30, 1951, Tawain, R.O.C.. Medical education, Kaohsiung Medical College, Taiwan, R.O.C., 1977. Fellowship, University of Southern California, Los Angeles. Residency, UAMS.

Chen-Hah, Marian M., Internal Medicine. Born September 9, 1965, Taiwan, R.O.C.. Medical education, University of Texas Health Science Center, San Antonio, TX, 1991. Internship/Residency, UAMS.

Clause, David B., Orthopaedics. Born April 28, 1960, Louisiana. Medical education, Tulane Medical School, New Orleans, LA, 1992. Residency, UAMS.

Davis, Kristie L., Anesthesiology. Born October 3, 1955, Memphis, TN. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1990. Internship/Residency, UAMS.

DeGraaff, Michael S., Anesthesiology. Born July 30, 1962, Cleveland, OH. Medical education, Indiana University, Indianapolis, IN, 1991. Internship/Residency, UAMS.

Fisher, Richard T., Pediatrics. Born August 24, 1965, Little Rock, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1991. Internship/Resideny, UAMS.

Grose, Andrew J., Internal Medicine. Born July 28, 1966, Michigan. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1992. Internship/Residency, UAMS.

Hadsari, Minoo H., Orthopaedics. Born December 29, 1960, Tehran, Iran. Medical education, University of Nevada School of Medicine, Reno, NV, 1984. Residency, UAMS.

Hardy, Ross A., Physical Medicine & Rehabilitation. Born April 26, 1964, Harrison, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1992. Internship/Residency, UAMS.

Hutchison, Timothy N., Anesthesiology. Born October 10, 1958, Key West, FL. Medical education, University of Tennessee, Memphis, TN, 1989. Internship, Methodist Hospital, Memphis, TN. Residency, UAMS.

Kozlovsky, John F., Opthalmology. Born January 9, 1964, Dallas, TX. Medical education, Baylor College of Medicine, Houston, TX, 1990. Internship, Baylor University, Dallas, TX. Residency, UAMS

Laffoon, Scott L., Family Practice. Born May 2, 1964, Paragould, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1990. Internship/Residency, AHEC-Northeast, Jonesboro, AR.

Langford, Timothy D., Urology. Born October 1, 1960, Searcy, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1988. Intership, Surgery, UAMS. Residency, UAMS.

Pearce, Jeffrey N., Anesthesiology. Born October 6, 1963, Oklahoma City, OK. Medical education, Oklahoma University Health Sciences, Oklahoma City, OK, 1989. Internship, University of Oklahoma, Oklahoma City, OK. Residency, UAMS.

Petkovich, Liliana N., Physical Medicine &Rehabilitation. Born February 3, 1939, Bulgaria. Medical education, Higher Medical Institute, Sofia, Bulgaria, 1970. Internship, Methodist Hospital, Memphis, TN. Residency, UAMS.

Sangster, Michael G., Dermatology. Born November 30, 1965, Warren, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1992. Internship/Residency, UAMS.

Shell, Michael G., Rehabilitation Medicine. Born August 13, 1960, Cincinnatti, OH. Medical education, Oklahoma State University College of Osteopathic Medicine, Tulsa, OK, 1990. Internship, Tulsa Regional Medical Center, Tulsa, OK. Residency, UAMS.

Shields, Eddie W., Pediatrics. Born September 27, 1963, Hot Springs, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1991. Internship/Residency, Arkansas Children's Hospital, Little Rock.

Strebeck, Sarah L., Psychiatry. Born October 21, 1965, Michigan. Medical education, University of Mississippi Medical Center, Jackson, MS, 1991. Residency, UAMS.

STUDENTS

Allen, H. Brad
Averitt, Susan M.
Baker, Karen F.
Bruton, Ronald F.
Bryant, Derek M.
Burke, Charles T.
Carnahan, Don A.
Coppola, Angelo, G.
Dugger, Joseph S.
Fielder, David G.
Fleniken, Ashley L.
Franklin, Patricia A.
Frost, Don A.
Gordon, Anthony K.
Gullic, Phillip T.
Hannah, James T.
Harper, Jon D.
Hix, Robert S.
Jackson, Hugh H.
Kruse, Lori L.
Lowery, Lisa A.
McDermott, Susan S.
McLellan, Matthew B.
Miller, Jeffrey J.
Paglianite, Samuel J.
Perkins, Rick A.
Richardson, LaWanna M.
Roman, Juan C.
Roush, Karen S.
Stewert, Rowland T.
Storey, Mark R.
Taylor, Chris W.
Tharp, Paul S.
Vest, Carl.E.
Wilson, John E.

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AMS Newsmakers

Dr. John D. Ashley of Newport won the first prize award in the portrait division of the American Physicians Artist Association annual show in San Antonio, which was held in conjunction with the Southern Medical Association's annual meeting.

Dr. Jimmy Darrell Bonner of Paragould has been named a Fellow of the American Academy of Family Physicians.

Dr. B. Eliot Cole of Pocahontas was recently selected as Co-Chair of the 1993 Annual Conference of the American Academy of Pain Management.

Dr. Jim English of Little Rock was elected vice president-elect of the southern region of the American Academy of Facial Plastic and Reconstructive Surgery at its 1992 annual meeting held recently in Washington, DC.

Dr. Clifford Lamar Evans recently opened the North Little Rock Radiation Oncology Center.

Dr. Fredrick Eugene Joyce, Jr. of Texarkana was honored for his commitment to Texarkana with the C.E. Palmer Award at the Texarkana Chamber of Commerce's 80th Annual Meeting.

Dr. Richard Douglas Justiss of Pine Bluff has been named a Fellow of the American Academy of Family Physicians.

Dr. Craig Maxey of Van Buren has been named a certified medical review officer.

Dr. Mike Moody from Salem has been recertified as a diplomate of the American Board of Family Practice.

Dr. J. William Nuckolls of Pine Bluff has been named the 1992 recipient of the Robert Shields Abernathy Award for Excellence in Internal Medicine by the Arkansas chapter of the American College of Physicians.

Dr. Joanna J. Seibert of Little Rock was recognized recently Sixth Annual Arkansas Professional Women of Distinction Awards Banquet.

Dr. Charles H. Stinnet of Siloam Springs has been recertified as a diplomate of the American Board of Family Practice.

Dr. Steve Wilson of Fort Smith recently gave the President's Address to the 71st Annual Meeting of the South Central Section of the American Urological Association in Galveston, TX.

John Steven Johnson, a medical student at UAMS, has been awarded the McMath Law Firm Scholarship for 1992-93.

The annual award was presented to Mr. Johnson at the annual College of Medicine Scholarship Banquet.

Mr. Johnson, of McRae, is a senior with a 3.9 grade-point average. He has been awarded the scholarship for three consecutive years.

The scholarship, which pays full tuition, is awarded each year to a sophomore medical student on the basis of superior academic performance during the first year of medical school and renewed each year, provided the student continues to excel.

Rob Emery, senior medical student, of Tulsa; junior medical student **Scott Stanley** of Little Rock and sophomore medical student **Scott Hogan** of Morrilton each have been honored as recipients of the Dean's Office-College of Medicine Scholarships at UAMS.

The scholarships were created to recognize and reward humanitarian public service "as demonstrated by superior awareness of and accomplishments in community and civic activities."

Kimberly Garner was awarded the Arkansas Academy of Family Physicians Foundation Annual Scholarship.

The scholarship was designed to recognize a junior student interested in family medicine on the basis of academic performance and community/civic involvement.

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ASYCHRONIS MEGABYTES ROM ARCNET
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BARCODE RE
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MAGNETIC MEDIA MGA
MONOGRAPHIC ADAPTER
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MULTI-USER ENVIROMNEN
NETWORKING
ACCEPT ASSIGNMEN
CROSSOVER CLAIM EDS
CHARGE SLIPS HMO WRITE-OFF
CURRENT PROCEDURAL TERMINOLOGY
OUTSIDE LAB CHARGES
SUPERBILL PPO
WORKMAN'S COMP
ICD DIAGNOSIS CODES
REFERRING PHYSICIAN SECONDARY
GROUP NUMBER HICFA
PLACE OF SERVICE CODE
PRIMARY CARRIER
PRIOR AUTHORIZATION
TYPE OF SERVICE CODES
SAME/SIMILIAR INDICATOR
PATIENT CHARTS DAY SHEETS
SUPERBILL
CPT PROCEDURE CODES
WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN
ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE
DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT
APPROVED AMOUNT TYPEWRITER
CODING REQUIREMENTS
APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES DATE OF DISABILITY
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Medicine in the News

Health Care Access Foundation Update

As of December 1, 1992, the Arkansas Health Care Access Foundation has provided free medical service to 5,883 medically indigent persons, received 10,455 applications, and enrolled 21,622 persons.

The program has 1,491 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

Arkansas Foundation for Medical Research Opens

A new medical-research foundation begun by a Hot Springs neurologist, Dr. Richard Pellegrino, officially opened on December 3.

The Foundation's research will target strokes, Alzheimer's disease and multiple sclerosis by offering drug testing trials to people who are willing to try experimental treatments.

Two experiments already have begun, one is testing a drug that might stem memory loss among Alzheimer's patients and another is on ways to prevent blood clots in the neck artery.

There are plans for the Foundation to present programs that would teach doctors about strokes and Alzheimers at the Arkansas Medical Society's Annual Session every other year.

Arkansans Ship Medical Supplies to help Somalis

Medical supplies donated by Arkansans were flown from Little Rock Air Force Base, destined for the Horn of Africa to help thousands of refugees in besieged Somalia.

Antibiotics, surgical supplies and other medical equipment that will be used in a field hospital were loaded onto an Air Force C-141 and will be delivered to Mombasa, Kenya. Mombasa is the staging area for the U.S. humanitarian airlift into Somalia, which is called Operation Provide Relief.

It was the first such shipment of donated medical supplies from the United States.

Dr. Jay Holland, a family physician from Little Rock and an Arkansas Medical Society member, helped spearhead the effort to collect the medical equipment.

Study Reveals Simple B Vitamin can Reduce Birth Defects

Taking folic acid - one of the B vitamins - before pregnancy can substantially reduce the risk of having a child with spina bifida, researchers in Little Rock announced recently.

Arkansas had the highest incidency rate for spina bifida from 1983 to 1990 in a study of 16 states conducted by the national Centers for Disease Control.

Scientific literature says that spina bifida may be caused by exposure to toxins or may also be a genetic problem, affecting people of Irish or Welsh descent. And women who have had one child with a neural tube defect are two to five times more likely to have another child with such a birth defect.

However, taking a daily dose of 4 milligrams of folic acid per day during the time just before pregnancy can reduce the chance of having a baby with a neural tube defect from 50 to 75 percent. Taking the dose immediately after the pregnancy begins can reduce the severity of the defect. The water-soluble vitamin is available through fortified cereals and most multivitamins. Doctors Gerald Quirk and Chris Chuniff co-directed the Arkansas Genetics Program. Dr. Quirk is chairman of the UAMS Medical Center Ob/Gyn Department and an Arkansas Medical Society member.

State Drops from 1st to 9th in TB Statistics

Arkansas appears headed in the right direction in incidence of tuberculosis - from sixth in the nation in 1990 to ninth in 1991, according to information from the federal Centers for Disease Control in Atlanta.

That is a considerable improvement for the state, which in 1986, ranked No. 1 in the nation in the incidence of tuberculosis.

That year, the state had 17.9 cases per 100,000 population - not only the nation's highest per capita rate, but also almost twice the national average of 9.4 cases per 100,000 population.

In 1991, Arkansas had 282 cases for a case rate of 11.9, dropping the state to 9th in the nation.

UAMS Awarded $75,000 for Eye Research

John S. Penn, Ph.D., research coordinator for the Arkansas Center for Eye Research at the University of Arkansas for Medical Sciences, has recently received the "Dolly Green Scholar Award" from Research to Prevent Blindness, Inc. (RPB).

This $75,000 research award will go toward Penn's investigation of causes, treatment and prevention of blinding diseases. It was offered as part of RPB's effort to

recognize unusual significance and promise in research done by outstanding young scientists in the United States. Having established itself as the world's leading voluntary organization in eye research, RPB has awarded more than $160,000 to eye research at UAMS. Dr. Penn is the first scientist at UAMS to receive an award of this stature.

Pharmaceutical Research Companies Testing 92 AIDS Medicines

According to a new survey by the Pharmaceutical Manufacturers Association, America's pharmaceutical research companies are developing 91 medicines for AIDS and AIDS-related conditions, The report, "AIDS Medicines in Development", lists 95 research projects involving these medicines under way by 66 pharmaceutical companies.

Because of the increasing incidence of AIDS in women and the continued incidence of AIDS in children, this annual survey, for the first time, tracked clinical trials that focus on meeting the specific requirements of women and children with AIDS. The survey results show that 50 of the medicines in development include women in clinical trials and 13 include children.

The survey also found that three new medicines have been approved by the Food and Drug Administration for use by physicians since the PMA's last survey of "AIDS Medicines in Development" a year ago. This brings the total to 17 of approved medicines for AIDS and AIDS-related conditions. Another 11 medicines are awaiting approval at the FDA.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), P.O. Box 5776, Little Rock, AR 72215. Call the Society at (501) 224-8967 or 1-800-542-1058 for more information.

In Memoriam

Thomas Earl Williams, M.D.

Dr. Thomas Earl Williams, a Newport physician, died Thursday, November 5, 1992. He was 84.

He was a member of the Arkansas Medical Society and the Jackson County Medical Society.

Dr. Williams is survived by his wife, Clyde Kendrick Williams of Newport; a son, Thomas K. Williams of Rosie; two daughters, Amelia Frankum of Newport; and Martha Latham of Jackson, MS; a sister, Ida A. Whitcomb of Corpus Christi, TX; and seven grandchildren.

Amelia "Meo" Hoffman John

Mrs. Amelia "Meo" Hoffman John of Stuttgart, died Sunday, December 6, 1992. She was 84.

Survivors are her husband, Dr. Milton Carr John; a daughter, Meredith John Spann of Little Rock; two sisters, Dorothy Rhodes of Memphis, TN and Marie Applewhite of Miami, FL; and two grandchildren.

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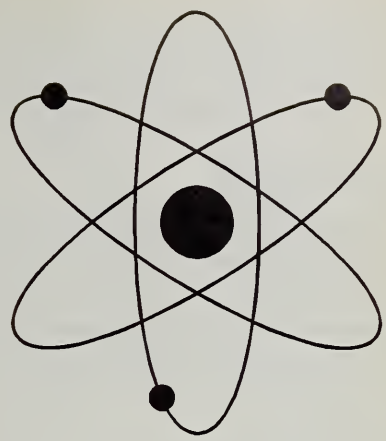
Radiological Case of the Month



David L. Harshfield, M.D.
Kelly Grigg, B.S.
Maria C. Porter, M.D.

History:

The following describes two patients, both of whom presented with dysphagia. Performance of a CT of the chest through the mediastinum revealed almost identical abnormalities along the course of the esophagus at the level of the carina. The patient in Figure A, in addition to a history of dysphagia, had a history of seminoma which had been successfully treated ten years ago. The patient in Figure B had a history of smoking and ethanol abuse, but no other significant clinical history.

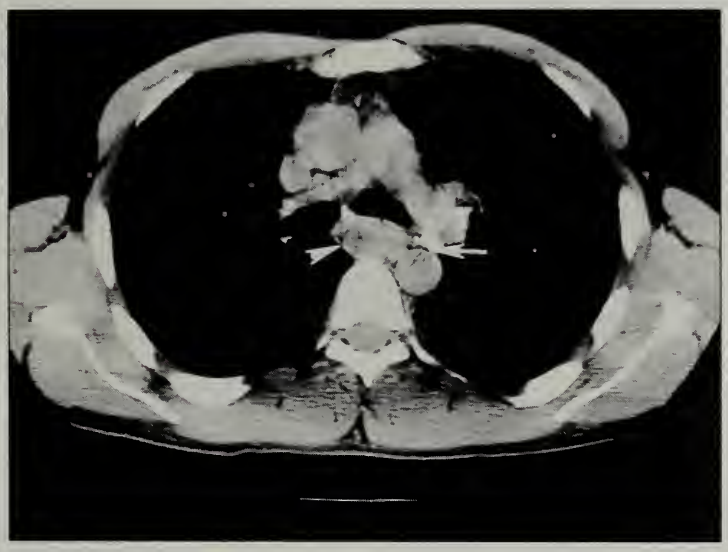


Figure A: The examination reveals the mass (arrowhead) along the course of the esphagus at the level of the carina. There is evidence of an intact fat plane between the enlarged esophagus and the descending aorta at the level of a calcified left hilar lymph node (large arrow).

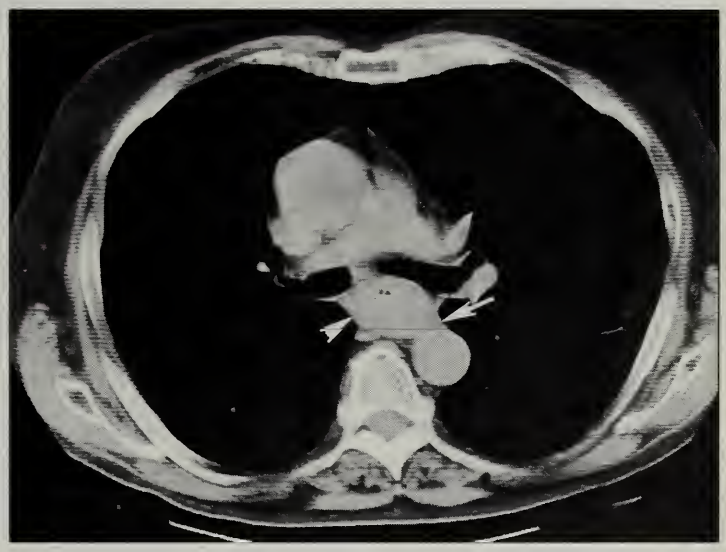


Figure B: The examination reveals a mass along the course of the esophagus (arrowhead) with two small air bubbles representing the lumen of the esophagus. Note the loss of the fat interface between the esophagus and aorta (large arrow).

Diagnosis

Figure A was a leiomyoma and Figure B was a squamous cell esophageal carcinoma.

Findings:

These two clinically and radiologically similar cases point out the difficulty in making "historical diagnosis" based on clinical and radiographic findings. These two CT scans are identical aside from the fact that in Patient B there appears

to be edematous effacement of the fat plane separating the esophagus from the descending aorta (which is considered to be consistent with an aggressive process such as inflamation or neoplasia). Although the fat plane is intact in Patient A between the esophgeal mass and the descending aorta and is considered a finding of benignancy, this can also be seen in more aggressive processes.

Discussion

Patient A had a leiomyoma of the esophagus. Benign tumors of the esophagus are two main types: 1) epithelial tumors arising from mucosa and 2) non-epithelial tumors arising from the wall. Tumors of mucosal origin, usually papillomas or adenomas, tend to be smooth and intraluminal. Tumors of non-epithelial origin such as this leiomyoma, as well as fibromas or lipomas, arise in the wall and may grow either inwards or outwards. Although both types of benign tumors may produce symptoms of dysphagia as in this patient, they are frequently found by chance.

Patient B has carcinoma of the esophagus which occurs more commonly in men than women. The tumor which starts as a mucosal lesion, spreads both around and along the length of the esophagus. The main symptoms are dysphagia, pain, and weight loss. Carcinoma of the middle third of the esophagus, particularly when at the level of the bifurcation of the trachea as in this case, may involve the trachea and bronchi by direct extension.

These two almost identical CT scans of patients who are clinically inseparable points to the importance of the pathologist in the diagnosis of many diseases, not just of the GI tract. Often times imaging features are "pathopnemonic" for a disease process, and we confidently accept the radiograph as the final diagnosis. This case demonstrates the important role the pathologist plays in our ability to make accurate diagnoses.

Reference:

David Sutton: A Textbook of Radiology and Imaging - Third Edition Volume Two, 1980.

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Things To Come

January 17-19

Ambulatory Gynecology. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

January 24-30

19th Annual Midwinter Program for Physicians. Incline Village, NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

February 5-6

11th Annual Infectious Disease Conference. Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

February 20

Cardiology for the Primary Physician. University of California Davis Medical Center, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. Fees: $90/Physicians, $70/Others. CME accreditation offered. For more information, call (916) 734-5390.

February 21-26

Emergency Medicine. Hyatt Regency, Incline Village (North Lake Tahoe), NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. Fees: $425/$325, past participant; $465/365, non-past participant. CME accreditation offered. For more information, call (916) 734-5390.

February 25-28

The 11th Annual International Symposium on Man and His Environment in Health and Disease. The Southland Center Hotel, Dallas, TX. Sponsored by The American Environmental Health Foundation. Fees: $360/410, physcians; $310/360, allergy, nurse assistant, other; $15, students, residents, interns. CME accreditation offered. For more information, contact Laura Gibson, (214)373-5164 or Sally Smith, (214)373-5161.

February 27

Office Laboratory Seminar. Holiday Inn West, Little Rock. Sponsored by the Arkansas and American Academies of Family Physicians. Fees: $125. CME accreditation offered. For more information, contact the Arkansas AFP at (501)223-2272 or the American AFP at (800)274-2237, ext. 5440.

March 6-11

20th Annual Critical Care Medicine Course. Oklahoma City Marriott Hotel. Sponsored by the Department of Medicine, College of Medicine, The University of Oklahoma Health Sciences Center and the Veterans Affairs Medical Center in conjunction with the Office of Continuing Medical Education. Fees: $650. CME accreditation offered. For more information, contact Dora Lee Smith at (405) 271-5904.

March 6-13

Update in Clinical Medicine. Vail, Colorado. Sponsored by The George Washington University Medical Center, Office of Continuing Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202)994-4285.

March 8-12

Radiation Safety Specialist Training Program. Oklahoma City, OK. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

March 10-13

Health Care '93. Sunshine City Exhibition Center, Ikeburuko, Tokyo. Sponsored by JETRO (Japan External Trade Organization). For more information, call JETRO-Houston (713) 759-9595.

March 13

Women's Health and Breast Cancer. University of California, Davis, Medical Center, Cancer Center Auditorium, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the UC, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

March 18-20

Spring Break for CME. PGA National Resort & Spa, Palm Beach Gardens, FL. Sponsored by the Florida Medical Association. CME accreditation offered. Fees: $385. For more information, call (904) 356-1571.

March 25-27

Laboratory Workshop in Breast Reconstruction. Sentara Norfolk General Hospital, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of

Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 2-3

Ambulatory Pediatrics. Sacramento Inn, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

April 2-3

Fighting for their Lives: You Can Make a Difference-HIV Update. Cancer Center Auditorium, UC Davis Medical Center, Sacramento, CA. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine. CME accreditation offered. For more information, call (916)734-5390.

April 8-9

Hands-On Workshop on Advanced Diagnostic Methods in Andrology. Jones Institute of Reproductive Medicine, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 16-18

43rd Annual Postgraduate Symposium on Anesthesiology. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the Department of Anesthesiology, the University of Kansas Medical Center. CME accreditation offered. For more information, call (913) 588-4488.

April 18-20

13th Annual Meeting of the American Society for Laser Medicine and Surgery. Marriott Hotel, New Orleans, LA. CME accreditation offered. For more information, call (715) 845-9283.

April 23

Thrombolysis: It's Role in Peripheral, Arterial and Venous Disorders. Omni International Hotel, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 23-24

5th Annual Pediatrics & All That Jazz: Current Practice and Recent Advances. Brent House Hotel, New Orleans, LA. Sponsored by the Alton Ochsner Medical Foundation, New Orleans. For more information, call (504) 842-3702.

April 23-24

29th Annual Orthopaedic Symposium--Diagnosis and Treatment of Diseases of the Cervical Spine. The Houstonian Hotel and Conference Center, Houston, TX. Sponsored by St. Luke's Episcopal Hospital. For more information, call (713)791-4200.

April 26-30

Radiation Safety Instrumentation & Compliance. Sheraton Plaza Hotel, Orlando, FL. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

April 29-May 2

Clinical Electrocardiography: Basic Concepts & Interpretation - 13th Edition. Ritz-Carlton Hotel, Philadelphia, PA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 30-May 2

Pathology of HIV. Arlington, VA. Sponsored by The George Washington University Medical Center, Office of Continuing Medical education. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, (202)994-4285.

May 6-9

Practical Dermatology for the Primary Care Physician - 19th Edition. Ritz-Carlton Hotel, Pentagon City, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

May 13-16

Central Atlantic Seminar in Anesthesiology. Washington, DC. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202)994-4285.

June 3-5

3rd International Biological Effects of Light Symposium. Wenkenhof Riehen meeting Center, Basel, Switzerland. Sponsored by the Light Symposium Foundation. For more information, call Scott B. Watt at (404) 432-2409.

June 6-11

9th Annual EVMS Family Medicine Review Course. The Cavalier Hotel, Virginia Beach, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

June 12-16

Board Review in Family Practice. Arlington, VA. Sponsored by The George Washington Universtiy Medical Center. For more information, contact John F. Vargo,

George Washington University Medical Center, Office of CME, (202)994-4285.

June 25-27

11th Summer Symposium in Internal Medicine. Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

July 6-10

16th Annual Flap Dissection Workshop. Virginia Beach Conference Center, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

July 29-August 1

46th AAFP Annual Scientific Assembly. Excelsior Hotel and Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME accreditation offered. For more information, call (501)223-2272.

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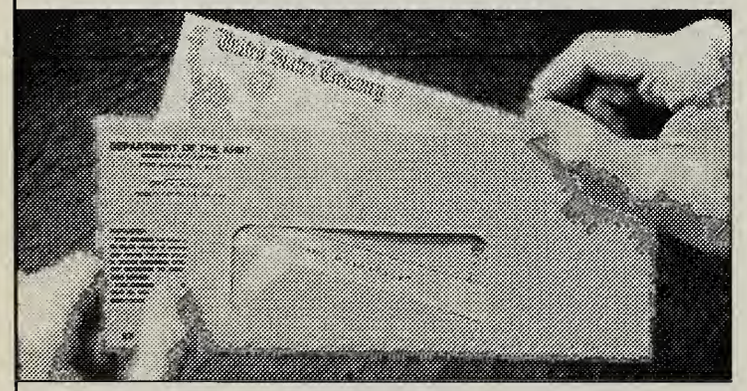

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3rd Annual Physician Update Weekend

February 13, 1993, Center for Health Education, St. Vincent Infirmary Medical Center, Little Rock. Sponsored by Office of Continuing Medical Education, St. Vincent Infirmary Medical Center. 6 hours Category I available. Registration fee, $25.00.

Annual Cardiovascular Update

February 19, 1993, J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Sponsored by Medical Education, Baptist Medical Center. 7.75 hours Category I areavailable.

Family Medicine Spring Academic Conference

May 21-23, 1993, Holiday Inn West, Little Rock. Sponsored by University of Arkansas for Medical Sciences Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

Infectious Disease Update

April 2 & 3, 7:30 a.m. - 12 noon, The Park Hilton, Hot Springs. Sponsored by Arkansas Children's Hospital, Department of Pediatrics/UAMS. CME Category I credits available. Fee: $100.00.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

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CME Luncheon for Medical-Dental Staff, January 22, February 12 & 26, 12:30 p.m., Ozark-Quapaw Room

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Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla Room. Lunch provided
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla Room. Lunch provided
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla Room. Lunch provided
Interdisciplinary AIDS Conference, second Friday, 12:00 noon, Southwestern Bell/Arkla Room. Lunch provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Category 1 credits available. Lunch provided
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thrusdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D

Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, 4th Thursday, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Pre-op/Didactic Conference, Mondays, 5:00 p.m., VAMC-LR, 4D
Urology Radiology Conference, 1st Thursday, 5:00 p.m., UAMS, Radiology Department
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Urology VA Teaching Rounds, every Friday, 7;30 a.m., VAMC-LR, 4d
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room
Tumor Conference, 1st Thursday, 12:00 noon, Assembly room

EL DORADO - AHEC

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH - AHEC

Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Pediatric Advanced Life Support Course, December 11-12, AHEC
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club

Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st - 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" or 3 1/2" diskette containing the manuscript. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

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References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the authors(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

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PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General.**)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N=900)	Placebo (N=411)	Pravastatin (N=900)	Placebo (N=411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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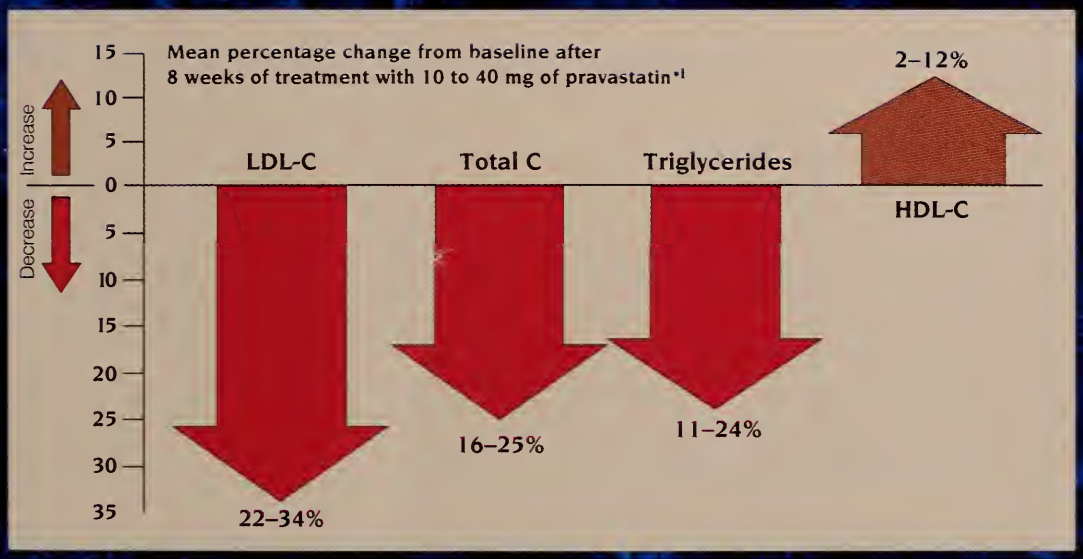

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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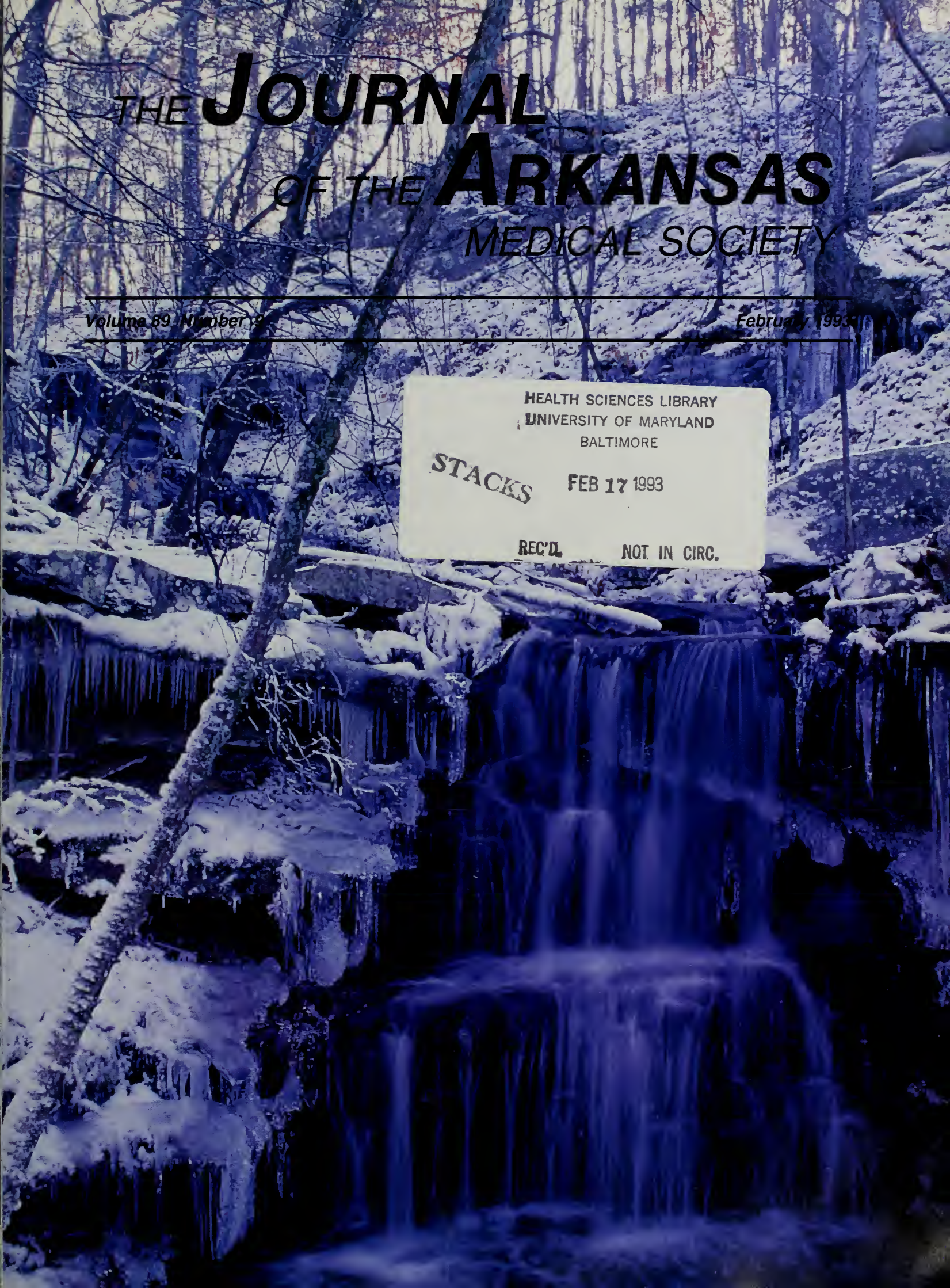

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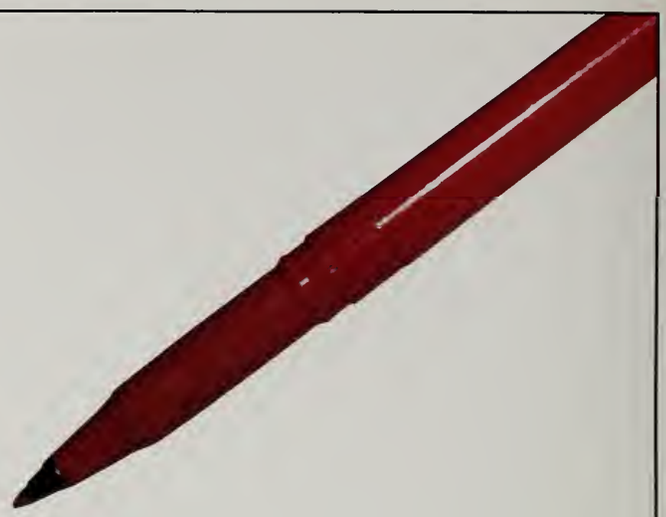

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Chief Complaints: The History of Present Symptoms

Lee Abel, M.D.*

Most physicians have relatively little knowledge of past medical practices. Perhaps we have sat through a few lectures on "The History of Medicine" but really have little knowledge of what physicians in past times believed and how their beliefs affected their practice. We know the names Osler, Virchow, Charcot, for example, but how they practiced remains a vague blur to us. I have recently read a fascinating book by historian Edward Shorter titled *From Paralysis To Fatigue: A History of Psychosomatic Medicine in the Modern Era.*[1] This book gives remarkable historical insights into an important area of medicine, psychosomatic illness. The author provides a detailed and dramatic history of psychogenic symptoms. It is a history of "shifting maladies as experienced by patients and perceived by doctors, an account of how historical eras shape their own symptoms of illness."

Shorter's thesis is that as the medical model of organic disease changes over time, it influences the psychogenic symptoms patients complain of. This is because psychogenic symptoms are the unconscious mind's response to stress or unhappiness. The unconscious mind is under great cultural pressure, though, to produce only "legitimate symptoms," or else it runs the risk of not being taken seriously. As doctors (and society in general) change their mind about what are legitimate symptoms and what are not, the pattern of psychosomatic illness changes.

This idea is probably not too foreign to most doctors. A recent example would be any of the "fad" diagnoses of the last decade or two such as hypoglycemia. Another example is mitral valve prolapse which, as a diagnosis to explain multiple somatic symptoms, has generally fallen out of favor over the last few years with physicians. Correspondingly, it is now relatively rare for a patient to be preoccupied with mitral valve prolapse, and to present complaining of multiple symptoms due to this entity. Another glimpse of the cultural context of symptoms is the fact that, although human physiology doesn't change from country to country, symptoms may vary widely among different cultures.

Shorter describes past ills such as fits, paralysis, spinal irritation, drawing up, Charcot's hysteria, and catalepsy, which once were almost epidemic but now are almost never seen. The doctors' treatments of these entities creates somewhat harrowing tales. The litany of procedures such as clitoridectomy, leeches, blisters, and cautery seem quite barbaric. A few of the treatments sounded attractive like the "spa cures" which were popular with the affluent. One of the most striking things was the absolute assurance of physicians that their theories were correct, and their treatment efficacious. And, of course, a good blistering of the skin by applying caustic material often did succeed at "curing" the symptoms, at least for a time. But too often the treatments just created real disease and disability and caused more patient focus on symptoms, and so a downward spiral ensued. This slippery slope is well-known to modern-day physicians. Inevitably, this historical perspective makes us wonder what beliefs and treatments of our own will be looked on as utter foolishness by future physicians.

The doctor's dilemma is that the differentiation of organic from psychogenic disease is often very difficult. We are all very aware that there is a long history of physicians treating patients for "nerves" when later science showed organic disease such as multiple sclerosis or Addison's disease to be the true cause. Shorter quotes Doctor Harry Parker of the Mayo Clinic who, in 1926, said, "There is a deep and troublesome fear that [the doctor's] diagnosis may be mistaken. To make a frank diagnosis of hysteria always means that the bur-

* Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic.

den of proof rests on [the doctor's] shoulders and the only proof is that he has the ability to cure the disease by simple psychogenic means." Another problem was pointed out by William Osler in 1892 in regards to hysterical joint ailments: "Perhaps no single affection has brought more discredit upon the profession, for the cases are very refractory, and finally fall into the hands of a charlatan or faith healer, under whose touch the disease may disappear at once." The current popularity of alternative healers is testimony to the fact that physicians still have much difficulty in treating patients with psychogenic symptoms.

Where the book becomes controversial is in Shorter's analysis of our present condition. The author pulls no punches and presents his ideas with great assurance. He outlines why present day somatizing patients reject any psychological interpretation of their symptoms. He quotes Rudolf Schindler, an internist in Munich in the 1920s (and the inventor of the flexible gastroscope) as saying "They have no idea that they have a nervous or indeed a psychiatric illness, and they refuse to believe it when you say it to them short and sweet. For what is making them ill lies beneath the threshold of their consciousness." Shorter notes that this "lamentation about the lack of insight in somatizing patients constitutes a steady stream in medical literature." As a response to patients who demand an explanation and diagnosis for their symptoms, doctors, Shorter asserts, have developed a management strategy he calls "Seek out the convenient fiction." Symptoms such as pain and fatigue "cry out for attribution to a 'real' organic disease because sufferers find them so bewildering and intolerable." Thus Shorter describes a succession of diagnoses such as colitis, neurasthenia, chronic brucellosis, candida hypersensitivity, environmental allergy, fibrositis, and the chronic fatigue syndrome.

Shorter sees several things unique to our present time that did not characterize the management of psychosomatic illness in past times. The first of these is mistrust of physicians. Shorter claims this is a relatively new phenomenon which makes the management of psychogenic symptoms more difficult. Indeed he states that the "mistrust of the doctor and refusal to accept his or her reassurance gives somatization at the end of the twentieth century its particular stamp."

The second factor unique to our time is the fact that "advancing medical knowledge [has] had the ironical result of driving somatization deep into the nervous system, where a 'million-dollar workup' would be required to clarify matters." Pain and fatigue have become the predominant psychogenic symptoms of our time and being highly subjective "neither. . . can be said not 'really' to exist" and are "almost impossible to disprove."

The third factor is what Shorter calls the "subculture of illness" that supports patients in maintaining their psychogenic symptoms. Central to this subculture are patient support groups, newsletters, and physician promoters. Illnesses like "food allergies and TMJ dysfunction of course exist, but most individuals who believe that they have these problems do not have them." Shorter makes this statement without giving any reference or documentation, although many physicians would probably agree with him. The support groups often promote their agenda with considerable ingenuity, as when the CDC's renaming of chronic Epstein Barr virus infection to the chronic fatigue syndrome "did not sit well with patient groups who promptly renamed their condition CFIDS, Chronic Fatigue Immune Dysfunction Syndrome, to better insist on its organicity."

The final new aspect to psychogenic symptoms in our time is the role of the mass media, which Shorter asserts "has started to take precedence over what was once called medical authority. The dominant medical paradigms of our own time fall unheeded in the babble of media interviews of physician-enthusiasts and wrenching accounts of patients' suffering. At the end of the twentieth century, the psychological paradigm remains the dominant medical explanation of somatoform symptoms, but this paradigm excites little interest among a press eager for sensation." We are all familiar with the power of the press in shaping what complaints patients come to the doctor for. Shorter points out how common it is for patients to have more than one "media popularized condition" such as mercury dental filling toxicity, Lyme Disease, Candidiasis hypersensitivity, and food allergy.

Edward Shorter's book has made a valuable contribution and you will no doubt find it very interesting and stimulating. The prevalence of hysterical paralysis in past times strikes us at first as merely a medical curiosity. However, it reveals the awesome power of the unconscious mind over the body, for these sufferers were not faking or malingering. They truly had no conscious ability to walk or move, yet nothing was wrong with them in an organic sense. Our modern -day patients truly do suffer from real pain and real fatigue. In treating these patients, we must remain humble about the present state of our medical knowledge. The chronic fatigue syndrome may turn out to encompass several entities, some organic, and some psychogenic. Indeed, we may even find the mind-body dichotomy breaking down in the future. The mysteries of this mind-body relationship are likely more complex than our current theories allow. When our science is scant, the art of medicine is often even more challenging. Perhaps our task is to nonjudgmentally accept and understand our patient's pain, and at the same time to promote healing and not continued sickness behavior.

1. Shorter, Edward. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. New York: The Free Press, 1992.

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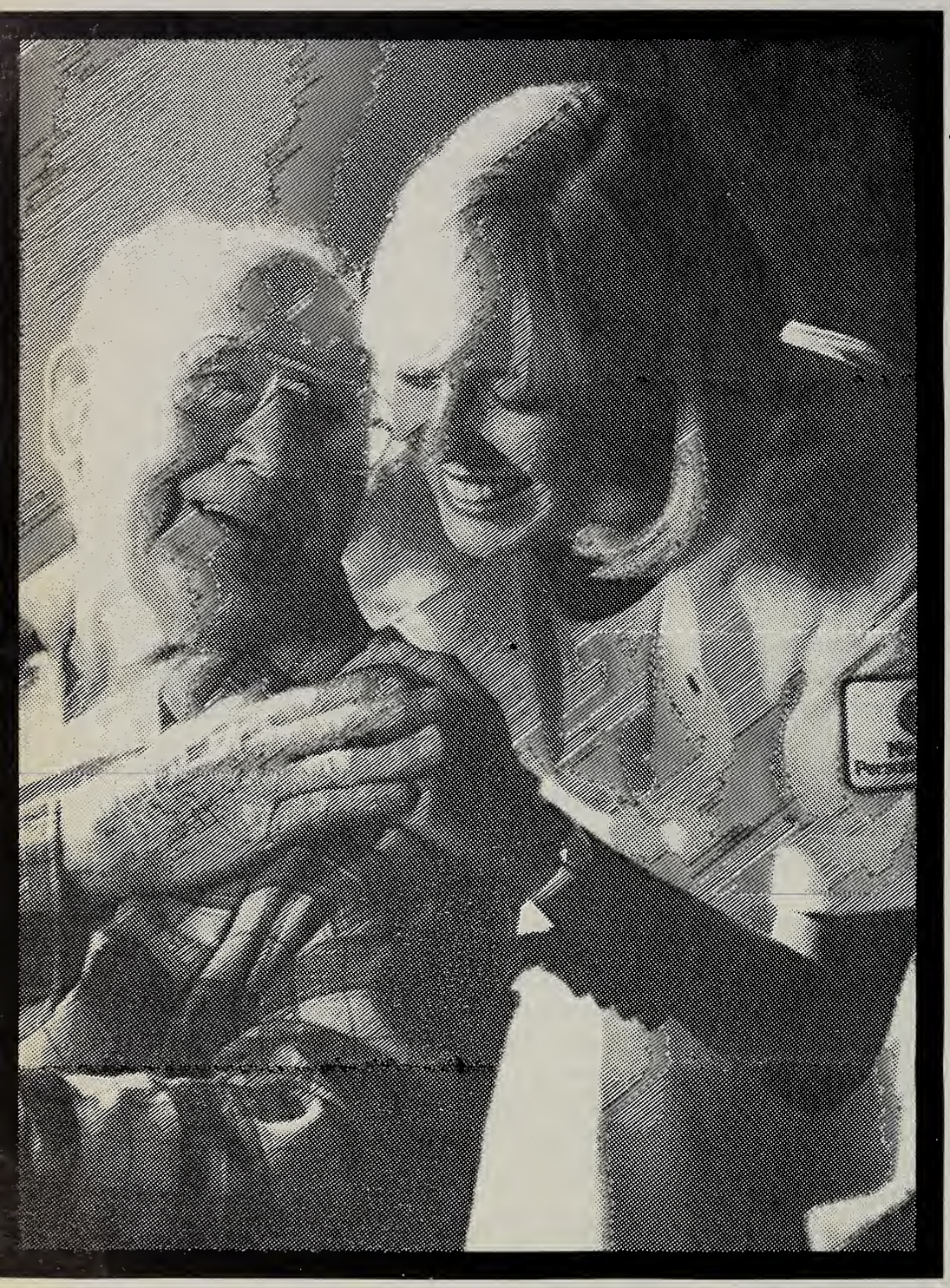

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Re: Arkansas Medical Society, et al v. Department of Human Services

Mike Mitchell, J.D.*

Background. Prior to the 1991 legislative session, DHS officials proposed that the medical provider community accept a 3.73% tax on fees charged for serving Medicaid patients in return for increased reimbursement equal to 80% of the Blue Cross Blue Shield fee schedule. Assurance were given by DHS officials that this would raise enough money to increase fees and increase eligibility. The medical community agreed to the proposal and the tax was passed. On July 1, 1991, reimbursement was increased to 80% of Blue Cross Blue Shield. Almost immediately DHS officials realized that there may be problems in meeting financial commitments. By January 1992, consideration was being give to reducing reimbursement. Without the notice required by the Administrative Procedure Act and under the Emergency Provision of that Act, DHS reduced reimbursement by 20% for all noninstitutional providers beginning July 1, 1992. The tax remained. Meanwhile, increases were granted to hospitals and nursing homes. While participation in the Medicaid program has always been poor in Arkansas, the situation was made even worse by the reduction in reimbursement. In some instances reimbursement after the reduction was less than it was before the increase. In many offices the reimbursement was not sufficient to cover overhead costs. Many medical providers began to limit or terminate their Medicaid practice.

The Law. The Medicaid program is voluntary state by state. However, if a state elects to provide a federal Medicaid program then the federal government will provide matching funds. In Arkansas, it is $3 for ever $1 of state money. In return, the state must adopt a plan for medical assistance that will comply with the federal regulations. For example, 42 C.F.R. § 447.204 requires reimbursement "be sufficient to enlist enough providers so that services under the plan are available to recipients <u>at least</u> to the extent that those services are available to the general population." The plan must be in effect in all political subdivisions of the state, must be furnished with reasonable promptness, be administered with simplicity and in the best interest of the recipient.[1] A special provision was enacted with reference to obstetrics and pediatrics. While no regulation has been formally enacted, DHS was instructed to follow the provisions of the Draft State Medicaid Manual, which requires that at least 50% of the obstetricians and pediatricians are full Medicaid participants or there is full participation at the same rate as Blue Cross Blue Shield participation.[2] The Manual defines "full participation" as "accepting all Medicaid patients who present themselves for care or treatment."

The Lawsuit. Faced with reimbursement that clearly did not provide equal access and with the continuation of the provider tax, the Council of the Arkansas Medical Society determined that the only recourse was a lawsuit to attempt to enjoin the 20% decrease in reimbursement. Given this mandate, a Complaint was filed on July 9, 1992 in Federal District Court in Little Rock. The first hearing was held on July 20. As a result of the hearing, Judge Wright rejected all the legal challenges raised by DHS and entered a preliminary injunction enjoining the defendant from implementing the 20% reduction in reimbursement rates in obstetrical and pediatric care as well as in speech, physical and occupational therapy for children. *Arkansas Medical Society, et al. v. Jack Reynolds*, LR-C-92-429, Memorandum and Order filed August 18, 1992. DHS has estimated that the enjoined reimbursements amount to approximately $12 million annually.

A second hearing was held August 18 and 19. In all, over 40 witnesses were called on behalf of the AMS. A Memorandum and Order was entered by Judge Wright on November 5. The court found in favor of the AMS on

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all legal challenges posed by DHS. However, the court refused, pending final trial, to extend the preliminary injunction to any other noninstitutional providers. *Arkansas Medical Society, et al. v. Jack Reynolds,* LR-C-92-429, Memorandum and Order filed November 5, 1992.

The trial on the merits began November 30 and lasted four days. In a surprise move DHS announced that it was withdrawing its application to reduce by 20% the reimbursement for obstetrics and pediatrics. On the stand, under oath, Ray Hanley testified that even though the decision could be changed they felt it was a final decision. Evidence was presented at trial showing that there was not equal access by Medicaid recipients. Direct interview surveys to physicians' offices, which experts tell us underestimates by 40% the amount of Medicaid participation, nevertheless showed a failure of equal access in many counties in Arkansas. The most acute areas are as follows: northeast Arkansas (Mississippi, Craighead, Crittenden, Cross); north central Arkansas (Boone and Searcy); northwest Arkansas (Washington, Sebastian and Franklin); southwest Arkansas (Miller, Hempstead and Columbia); and central Arkansas (Saline, Garland and Hot Spring). Testimony from Medicaid recipients, targeted case managers, Health Department directors and providers proved that Arkansas has a substantial and acute access problem for Medicaid recipients. DHS called only three witnesses, who testified generally that participation was fine and access was good.

Under the present law of this case, we have a good chance for victory. However, the Health Care Financing Administration (HCFA) is in the process, according to DHS officials, of adopting regulations which may have a bearing on the case. Judge Wright has indicated she will take judicial notice of any subsequently enacted regulations. In the meantime, we have been instructed to supply the court with post-trial briefs before Christmas. A final ruling in the case is not expected until sometime next year.

In conclusion, the lawsuit has prevented the 20% cut scheduled for July 1, 1991 with respect to obstetrics and pediatrics. Hopefully, no matter what the final ruling is, DHS will comply with its stated intention to retain that reimbursement for obstetrics and pediatrics. However, experience with the Arkansas Medicaid Program tells us that such assurances are not reliable.

Notes

1. The Medicaid Act, 42 U.S.C. § 1396 (a).
2. HHS, 1990 Draft State Medicaid Manual § 6306.1.

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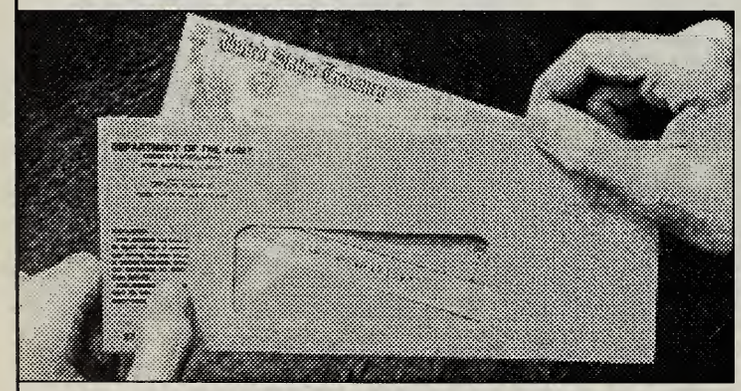

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"Doctor, I'm In Pain, But Please Don't Hurt Me."

Somatization Disorder: Diagnosis and Treatment

Kurt Dilday, M.D.*

Somatization Disorder, a psychiatric clinical syndrome, whose essential diagnostic features consist of physical symptoms suggesting a physical disorder, but for which there is no demonstrable pathophysiological explanation or organic pathology. The polysymptomatic syndrome is usually of several years duration. The disorder begins before the age of 30 and has a chronic, but fluctuating, course. The patients invariably seek medical attention, usually from several different practitioners and specialists of various types. They have complaints of numerous organ systems, including neurological, gastrointestinal, female reproductive, and cardiopulmonary symptoms. Associated features may include anxiety and depressed mood and the patients usually suffer from unnecessary medical and surgical intervention, including unnecessary surgery. The prevalence in the United States is estimated to be between one and two percent of the female population.[1]

The typical patient, when first seen by a psychiatrist, is usually a married woman in her 30's, with a dramatic and complicated past medical history.[2] A straightforward history of present illness is often difficult to obtain. There is considerable clinical literature testifying to a familial inheritance pattern to this psychiatric illness. Below are the diagnostic criteria for somatization disorder from the Diagnostic and Statistical Manual of the American Psychiatric Association, Third Edition, Revised.[1]

The essential features of this disorder are recurrent and multiple somatic complaints, of several years' duration, for which medical attention has been sought, but that apparently are not due to any physical disorder. The disorder begins before the age of 30 and has a chronic but fluctuating course.

Complaints are often presented in a dramatic, vague, or exaggerated way, or are part of a complicated medical history in which many physical diagnoses have been considered. Those affected frequently receive medical care from a number of physicians, sometimes simultaneously. (Although most people without mental disorders have aches and pains and other physical complaints at various times, they rarely bring them to medical attention.) Complaints invariably involve the following organ systems or types of symptoms: conversion or pseudoneurologic symptoms (e.g., paralysis, blindness), gastrointestinal discomfort (e.g., abdominal pain), female reproductive difficulties (e.g., painful menstruation), psychosexual problems (e.g., sexual indifference), pain (e.g., back pain), and cardiopulmonary symptoms (e.g., dizziness).

Age at onset. Symptoms usually begin in the teen years or, rarely, in the 20's. Menstrual difficulties may be one of the earliest symptoms in females, although preadolescents and adolescents may present with seizures, depressive symptoms, headache, abdominal pain, or a plethora of other physical symptoms.

Course. This is a chronic but fluctuating disorder that rarely remits spontaneously. A year seldom passes without some medical attention.

Impairment and complications. Because of constant consultation of doctors, numerous medical evaluations are undergone, both in and out of the hospital; there is frequently unwitting submission to unnecessary surgery. These people run the risk of Psychoactive Substance Use Disorders involving various prescribed medicines. Because of depressive symptoms, they may experience long periods of incapacity and frequently threaten or attempt suicide. Completed suicide, when it occurs, is usually associated with Psychoactive Sub-

* Kurt Dilday practices psychiatry in Little Rock.

stance Abuse. People with this disorder often lead lives as chaotic and complicated as their medical histories.

Prevalence. Studies have reported widely different lifetime prevalence rates, ranging from 0.2% to 2% among females, depending on whether the interviewer is a physician and on demographic variables in the samples studied.

Sex ratio. The disorder is rarely diagnosed in males.

Familial pattern. Somatization Disorder is observed in 10% to 20% of female first-degree biologic relatives of females with Somatization Disorder. The male relatives of females with this disorder show an increased risk of Antisocial Personality Disorder and Psychoactive Substance Use Disorders. Adoption studies indicate that both genetic and environmental factors contribute to the risk of this group of disorders, because both biologic and adoptive parents with any of these disorders increase the risk of Antisocial Personality Disorder, Psychoactive Substance Use Disorders, and Somatization Disorder.

Diagnostic Criteria for 300.81 Somatization Disorder

A. A history of many physical complaints or a belief that one is sickly, beginning before the age of 30 and persisting for several years.

B. At least 13 symptoms from the list below. To count a symptom as significant, the following criteria must be met:

1. no organic pathology or pathophysiologic mechanism (e.g., a physical disorder or the effects of injury, medication, drugs, or alcohol) to account for the symptom or, when there is related organic pathology, the complaint or resulting social or occupational impairment is grossly in excess of what would be expected from the physical findings

2. has not occurred only during a panic attack

3. has caused the person to take medicine (other than over-the-counter pain medication), see a doctor, or alter lifestyle

Symptom List

Gastrointestinal symptoms:

1. **vomiting (other than during pregnancy)**
2. abdominal pain (other than when menstruating)
3. nausea (other than motion sickness)
4. bloating (gassy)
5. diarrhea
6. intolerance of (gets sick from) several different foods

Pain symptoms:

7. **pain in extremities**
8. back pain
9. joint pain
10. pain during urination
11. other pain (excluding headaches)

Cardiopulmonary symptoms:

12. **shortness of breath when not exerting oneself**
13. palpitations
14. chest pain
15. dizziness

Conversion or pseudoneurologic symptoms:

16. **amnesia**
17. **difficulty swallowing**
18. loss of voice
19. deafness
20. double vision
21. blurred bision
22. blindness
23. fainting or loss of consciousness
24. seizure or convulsion
25. trouble walking
26. paralysis or muscle weakness
27. urinary retention or difficulty urinating

Sexual symptoms for the major part of the person's life after opportunities for sexual activity:

28. **burning sensation in sexual organs or rectum (other than during intercourse)**
29. sexual indifference
30. pain during intercourse
31. impotence

Female reproductive symptoms judged by the person to occur more frequently or severely than in most women:

32. **painful menstruation**
33. irregular menstrual periods
34. excessive menstrual bleeding
35. vomiting throughout pregnancy

NOTE: The seven items in boldface may be used to screen for the disorder. The presence of two or more of these items suggest a high likelihood of the disorder.[1]

Once the diagnosis of somatization disorder is obtained, numerous advantages are provided, both to the patient and the physician who is primarily responsible for this patient. First, hopefully, the patients have had a reasonable history, physical examination, and laboratory evaluation for any routine medical or surgical illness that could account for their symptoms.[2] After this is successfully completed, the patient who continues to frequent the doctor's office and requests pain medication and even requests surgical intervention will be addressed in a more appropriate fashion. The patient may be referred to a general psychiatrist for psychiatric evaluation and also treatment of other co-morbid psychiatric illnesses, such as Major Depression and Anxiety Disorder.[3] As with any patient, psychiatric or medical, follow-up is appropriate and a diagnosis of Somatization Disorder does not mean that the patient will not develop a medical or surgical illness over time. This will

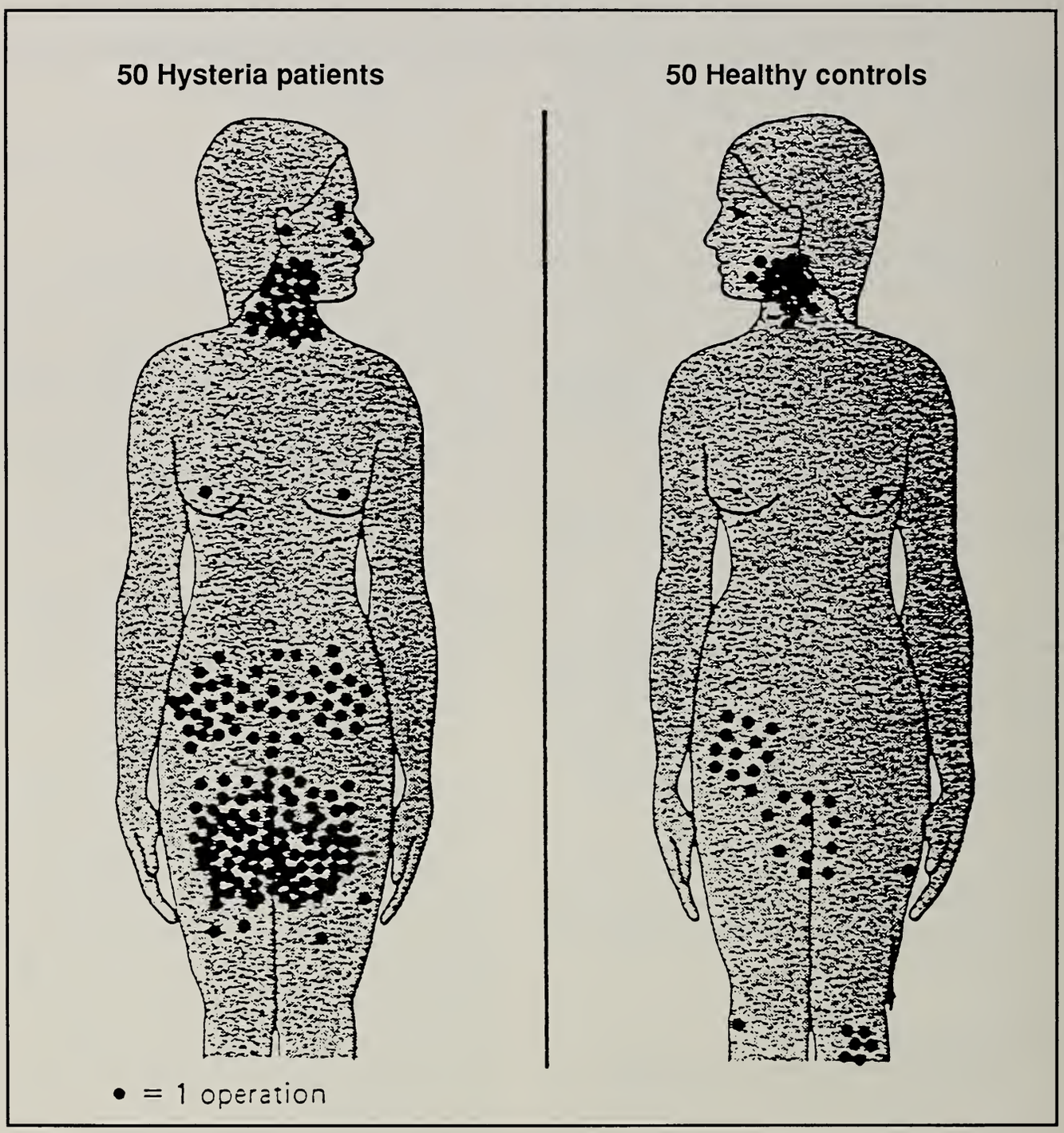

Figure 1 *Comparison of number and location of major surgical procedures in fifty hysteria patients and fifty healthy control subjects. By weight, it can be calculated that the mass of organs removed in hysteria patients is more than three times that in control subjects.*

justify diagnostic open-mindedness by the physician through time, but hopefully will prevent the patient and physician from engaging in over treatment of symptoms. These patients most often present to general and family practitioner offices and tend to elicit an irritated response from physicians because they are so bothersome and persistent with their symptoms that they are immediately referred to surgical or medical specialists for intensive treatment. Psychiatrists are especially trained to deal with the psychopathology of these disorders, with both psychotherapy and pharmacotherapy, as needed. These patients should not be given drug dependency prone compounds such as Benzodiazepines or Opioid narcotics for pain since they are prone to become drug dependent.[2]

Clinical Vignette: As a resident, while moonlighting in a community mental health center, I encountered a patient who met diagnostic criteria for Somatization Disorder. She was 22 years of age, had already had four abdominal surgeries and was being evaluated by a different surgeon for removal of her pancreas, "because of pancreatic carcinoma." She did not have any symptoms of a major malignant disease process. She appeared physically healthy; had a good appetite; and worked daily. Her past psychiatric history included being sexually abused as a child by a stepfather, growing up in an alcohol abusive home, having been married three times to alcohol abusing husbands, and was currently involved in a chaotic interpersonal relationship. She did not seem distressed about her symptoms and told me that she would still continue to see her several physicians and that each surgery she had had performed had been done by a different surgeon in different parts of the state. There was no evidence of psychosis but the patient met criteria for dysthymia, secondary type.

After establishing the diagnosis, I centered my treatment on trying to prevent unnecessary surgery in this patient. The patient also thought that she had cancer of the gall bladder and that she needed to have her gall bladder out. After consultation with her surgeon who, according to him, did not want to perform the surgery, but felt that her abdominal pain and distress may indicate some type of exploratory laparotomy, I suggested we wait since he did not have any objective diagnostic evaluation to testify that she did have an abdominal surgical illness. With his assistance and cooperation, the patient underwent weekly psychotherapy and a tricyclic antidepressant pharmacotherapy with marked resolution of her psychopathology and abdominal distress. With time, she changed relationships to a more stable lifestyle and successfully continued to be employed. Whenever she began to have pain, she returned for psychotherapy and, if needed, I would call her somatic physician to consult about the possibility of medical or surgical intervention. She remained reasonably asymptomatic for several years; did not have the extensive number of surgeries that we might have anticipated; and was later lost to follow-up after I completed my residency and returned to the state of Arkansas.

The above clinical vignette testifies to the importance of psychiatric consultation and follow-up with patients who have unexplained medical or surgical illnesses for which they desire treatment, but for which the somatic physician has no clear justification for performing. With psychiatrists, neurologists, surgeons, and internists working together, these patients can be diagnosed appropriately and given the correct and judicious medical, surgical and psychiatric treatment that they need.

Editorial Assistance: Cathy Van Cleve

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, third edition, revised. Washington D.C., American Psychiatric Association, 1987.

2. Kaplan H.I., Sadock B.J. Synopsis of Psychiatry. Ed. 5. Baltimore, Maryland. Williams and Wilkins, 1988.

3. Dilday, J. Anxiety Disorders: Diagnosis and Treatment. Journal of the Arkansas Medical Society, September 1991.

Bibliography

1. Goodwin, D.W., Guze, S.B. Psychiatric Diagnosis. Ed. 4. New York/Oxford, Oxford University Press, 1989.

2. Bernstein J. Handbook of Drug Therapy in Psychiatry. Littleton, Massachusetts. PSG Publishing Company, Inc.

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Arkansas HIV/AIDS Report 1983-1992

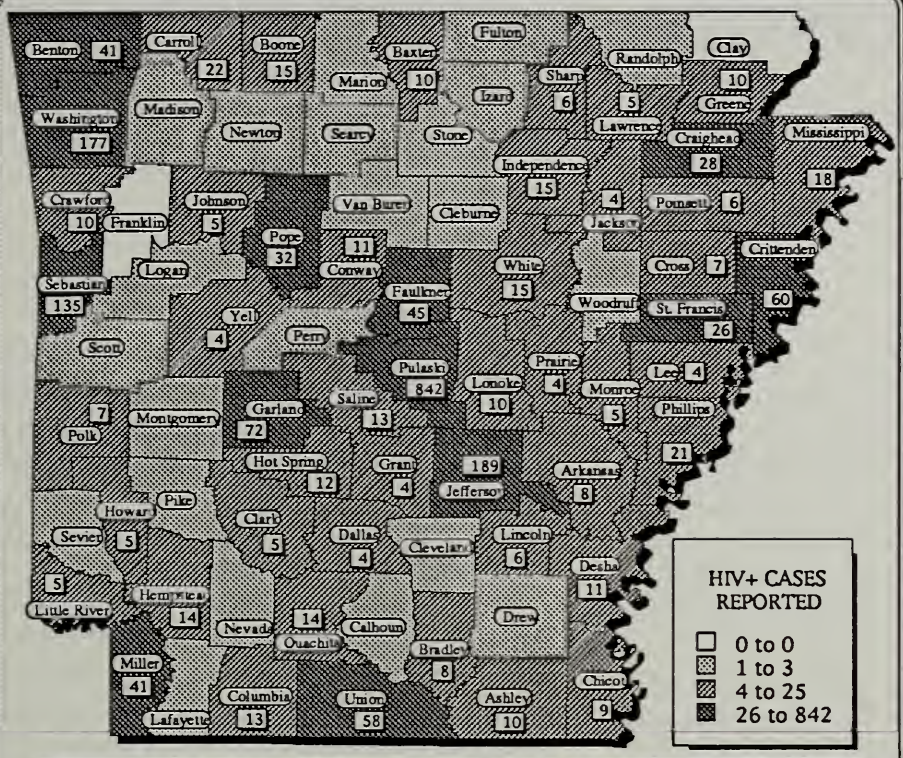
Arkansas: 1983 through December 25, 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	19	32	49	216	251	437	421	407	1,832	85.29
	Female	1	1	6	27	39	72	89	81	316	14.71
AGE	< 5	0	0	1	1	2	9	14	6	33	1.54
	5-12	0	0	0	1	1	5	2	2	11	0.51
	13-19	0	0	0	8	8	14	20	26	76	3.54
	20-29	8	10	15	109	125	192	154	164	777	36.17
	30-39	7	15	22	86	105	206	219	185	845	39.34
	40-49	4	7	11	24	35	62	74	67	284	13.22
	> 49	1	1	6	6	12	19	23	38	106	4.93
	Unknown	0	0	0	8	2	2	4	0	16	0.74
RACE	White	16	24	47	171	178	353	312	298	1,399	65.13
	Black	4	9	8	70	107	153	195	130	676	31.47
	Other	0	0	0	2	5	3	3	12	25	1.16
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	488	2,148	100%

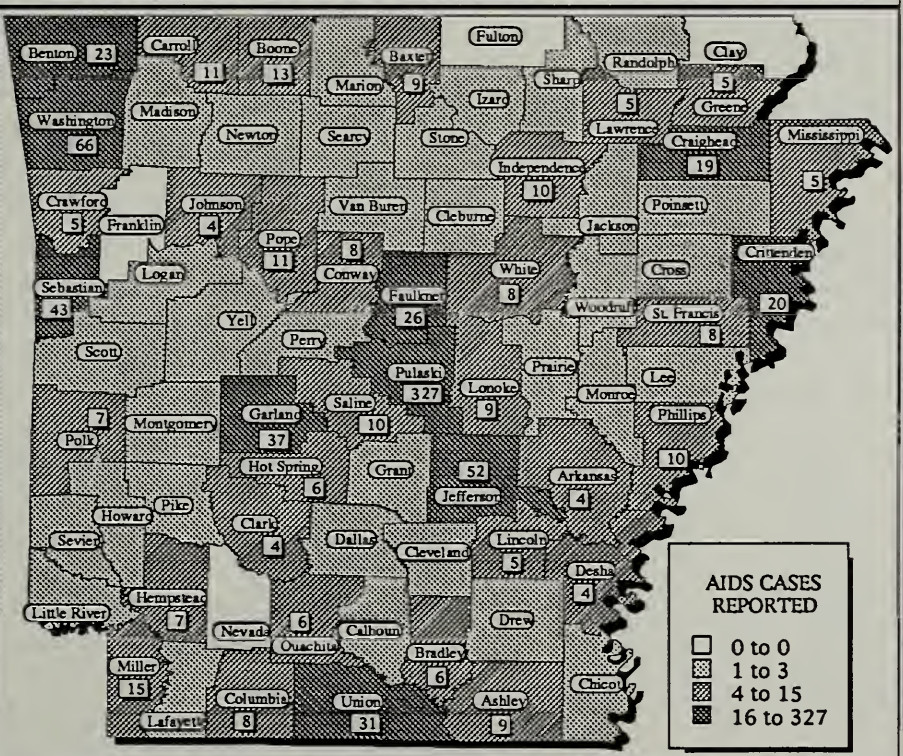
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
SEX	Male	11	28	46	77	70	170	176	250	828	89.13
	Female	1	0	4	6	10	20	25	35	101	10.87
AGE	< 5	0	0	0	1	1	6	6	3	17	1.83
	5-12	0	0	0	1	0	1	1	0	3	0.32
	13-19	0	0	0	0	0	4	3	2	9	0.97
	20-29	7	9	15	27	24	55	57	81	275	29.60
	30-39	3	13	23	36	41	78	80	128	402	43.27
	40-49	1	6	8	10	7	35	41	52	160	17.22
	> 49	1	0	4	8	7	11	13	19	63	6.78
RACE	White	9	22	43	61	58	141	134	207	675	72.66
	Black	3	6	7	20	21	47	66	74	244	26.26
	Other	0	0	0	2	1	2	1	4	10	1.08
RISK	Male/Male Sex	7	17	31	59	50	118	118	171	571	61.46
	Injection Drug User (IDU)	0	2	10	4	11	18	28	35	108	11.63
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	81	8.72
	Heterosexual	2	0	2	3	6	10	10	19	52	5.60
	Transfusion	0	0	2	7	3	7	11	3	33	3.55
	Perinatal	0	0	0	1	1	6	6	3	17	1.83
	Hemophiliac	0	0	0	1	1	5	5	4	16	1.72
	Undetermined	0	0	1	2	2	8	6	32	51	5.49
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	929	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1992



County of residence at the time of test for the 2,148 Arkansans reported to be HIV+. (12/25/92)



Of the 2,148 Arkansans reported to be HIV+, 929 have been diagnosed with AIDS. (12/25/92)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Continuing Supervision of Staff: A Necessity

J. Kelley Avery, M.D.*

Case Report

Our patient, a 58-year-old woman, had a modified radical mastectomy on the right eight years earlier because of breast cancer. She had been treated according to standard protocol, and following the surgery had had chemotherapy and radiation. She had done so well postoperatively that after the five years following the initial treatment had lapsed, her attending physician elected to see her annually.

At the eight-year annual checkup, the patient complained of a rather severe pain in the upper back and chest, which had begun only two or three weeks before. A physical examination did not reveal any significant abnormality. The mastectomy scar was examined thoroughly and a chest x-ray showed no evidence of lung pathology. Some symptomatic treatment was prescribed, and the patient was asked to return within a month if the pain continued.

The patient's pain became worse, and she did not wait a month to return, but returned to her primary care physician within two weeks. At this point the patient was sent to the operating surgeon for further evaluation.

Again, the physical examination showed no significant findings. It included a very thorough examination of the chest wall and axilla. Again, a routine chest x-ray was unremarkable. Because the patient's pain had gotten decidedly worse in the two weeks that intervened between her visit to her primary care physician and the appointment with her surgeon, a CT scan and a bone scan were ordered. Both showed evidence of metastatic disease in the upper thoracic spine and in the right clavicle.

Since the patient was having no neurologic symptoms except for the local pain, it was elected to treat her with chemotherapy to begin with, to be followed by radiation. She responded clinically to a course of chemotherapy with a marked reduction in pain, and the radiation therapy was to follow at an appropriate time after the completion of chemotherapy.

The lesions were evaluated and the radiation protocol was established, and the patient was to return at stated intervals until she had completed the radiation protocol. The patient followed the protocol precisely, and after completing all of the radiation, despite significant radiation sickness she did well for a very short time.

The patient began to complain of some numbness and weakness in her lower extremities. This rapidly progressed to involve the upper extremities, and she soon became quadriplegic, with only minimal function in the upper extremities, and a diagnosis of transverse myelitis due to radiation was made.

In reviewing the entire protocol for treatment, it was found that inadequate shielding had been used in the actual delivery of radiation to the prescribed sites on this patient's body. The same shielding had been used with every treatment, and was considered by all involved in the case, including the attending physician, to be the cause of the patient's disease. A six-figure settlement was negotiated.

Loss Prevention Comments

Catastrophes of this type do not occur often, but they do occur, and when they do they most often are due to a tragic mistake. There have been cases where the programming of the therapy unit had been at fault, and even though the appropriate dosage and length of time had been entered into the machine, due to the programming error the patient received much more radiation

* Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood, and medical director for Ambulatory/Outpatient Services, St. Thomas Hospital, Nashville.

than had been intended. This did not appear to be the problem in this case.

There have been cases where the supervision of the technical people involved with actually delivering the treatment has been at fault. Instructions that were less than precise, and failure to monitor with each treatment what the technician was actually doing may have played a part here.

Calibration of the machine has been a problem in some previous cases, but in this case that was not suspected.

Here we have a situation where everybody involved admitted that inappropriate shielding had been used. It was not done because nobody knew what was appropriate; it was simply because those responsible for setting up the machine for the treatments did not attend to their responsibilities adequately.

You may say that this kind of tragic error will occur despite all our efforts to prevent it. Perhaps that is true. However, if this happens to one of your patients, perhaps the pain of high malpractice insurance premiums will be the least pain you will have to endure. The much greater pain will be the memory of the damaged patient.

Had this particular event gone to a jury, it was feared that the degree of negligence would be such that punitive damage would have been called for.

To repeat, when one is involved in delivering this type of therapy, there simply must be precise calibration of the machine to be used, appropriate programming of the prescribed dosage and time into the unit, and close supervision of technical people. It appeared to be the last that produced this very tragic injury.

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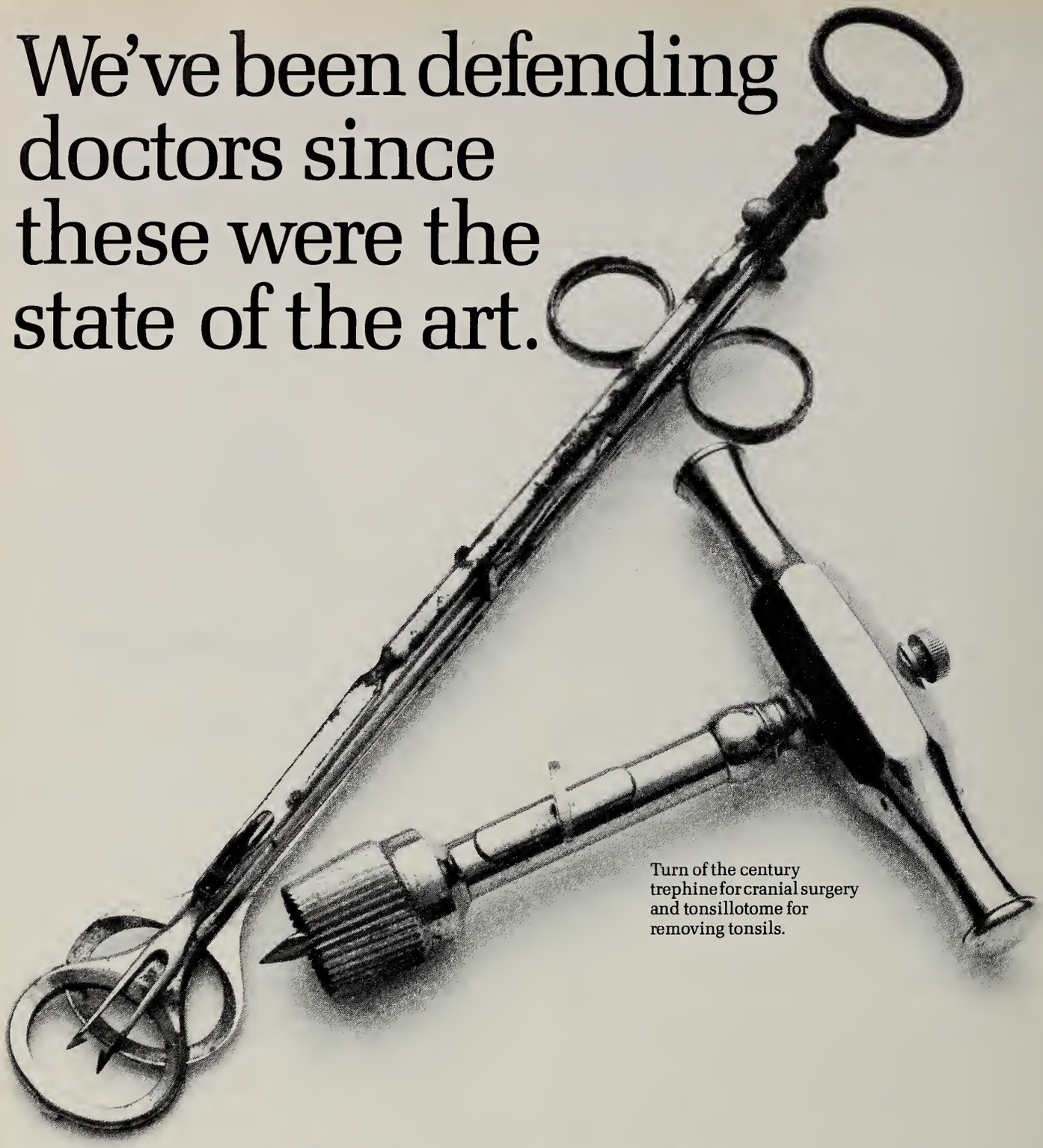

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Case Presentation of Coumadin-Induced Skin Necrosis

Connie L. Hiers, M.D.*

Coumadin has been used for many years for treatment of various thromboembolic disorders or prevention of such disorders. A significant adverse reaction from the use of coumadin is the development of skin and subcutaneous fat necrosis. Though the cause is not yet known, it is felt to be possibly related to depressed levels of protein C. One case is presented, as well as a review of the literature and a discussion concerning the etiologic effect and treatment.

Introduction

An unusual incidence of coumadin-induced skin necrosis is reported in an elderly female who was being treated for deep venous thrombosis. The patient had previously used coumadin with no complications. Skin changes were noted on the sixth day after initiation of coumadin.

Case Report

OB is a 77-year-old retired RN who had undergone a left total hip replacement for osteoarthritis. While the patient was recovering at the Rehabilitation Hospital, she developed a painful swollen left leg. Ultrasound performed showed deep venous thrombosis. The patient was then transferred back to an acute care facility for further treatment.

The patient's past history was significant for a long history of osteoarthritis, appendectomy, right ovarian cyst removal, dilatation and curettage, and an exploratory laparotomy for bowel obstruction. Her medications included Anacin No. 3. She had used coumadin for a short time several years ago, but had no documented CVA or pulmonary embolus. The patient had no hypertension, diabetes, or known cardiac disease.

Heparin was initiated, and two days later she was begun on coumadin. The initial dose of coumadin was 10 mg qd for three days, then 7.5 mg qd. Her PT levels ranged from 21 to 27. Her leg quickly responded to treatment, until the sixth day. She then developed a large area of erythema of her left lateral thigh, just below

Figure 1. Area of skin necrosis on lateral left thigh. The area involved is 40 by 20 centimeters with 30 by 15 centimeters of skin necrosis.

Figure 2. Defect after excision and debridement.

* Dr. Hiers is a physician associated with St. Bernard's Regional Medical Center, Division of Plastic Surgery, Jonesboro.

her healing incision. This erythema soon progressed to swelling with ecchymosis, then petechiae, then bullae, then necrosis. The involved area was 40 by 20 centimeters, with a 30 by 15 centimeter area of skin necrosis (figure 1).

Coumadin was stopped and heparin reinitiated. Ice packs and steroids were used. The patient ultimately required debridement and grafting. The area of necrosis was noted to involve the skin and subcutaneous fat, down to about 2 centimeters in depth (figure 2). Fortunately the debridement did not involve the previous hip incision. The wound slowly healed, and the patient was later transferred back to the Rehabilitation Hospital.

Discussion

Coumadin was first introduced in 1941. By 1943 Flood, et al, reported a case of breast necrosis following the use of coumadin. By 1988 over 200 cases had been reported, including 5 cases of penile necrosis. The usual patient was female, in the mid 50's, and obese. The levels of coumadin used were usually therapeutic or below. Skin necrosis usually became evident between the 3rd and 10th day after initiation. Forty percent of patients had multiple sites. The majority of involved areas included large amounts of subcutaneous fat, such as the abdomen, buttock, thigh, or breast. A unique category included the "purple toe syndrome," which occurred in certain patients.[2]

Several theories have been proposed to explain this development. It has been shown that it is not due to a hypocoaguable state. It does not appear to be a vasculitis or arteritis problem, since areas involved are not based on regional arteries. It does not appear to be a hypersensitive reaction, such as a localized Schwartzman reaction, since there is no identifiable eosinophilic infiltrate.

The most widely accepted theory is that of a lowered level of protein C. Protein C, a vitamin K-dependent glycoprotein, inactivates factors Va and VIIIa when activated by thrombin. Initiating the use of coumadin appears to cause a drop in the level of protein C. This appears to lead to the development of microthrombi in very small venules, and then on to the development of skin necrosis.[2]

Treatment of impending coumadin-induced skin necrosis includes stopping the coumadin and initiating high-dose heparin. Vitamin K and possibly fresh frozen plasma should be given in an attempt to elevate the level of protein C. Steroids, vasodilators, hypothermia, and even sympathetic nerve blocks have been used. Hyperbaric oxygen could also be of benefit.

Conclusion

There is a fairly significant morbidity of coumadin-induced skin necrosis. One may want to avoid large loading doses, especially in obese older women. This is a presentation of a case report of coumadin-induced necrosis six days after the initiation of coumadin in an elderly female.

References

1. Caldwell EH, Stewart S: Skin necrosis as a consequence of coumadin therapy. Plast Reconstr Surg 1983; 72: 231-3.
2. Cole MS, Minifee PK, Wolma FJ: Coumadin necrosis A review of the literature. Surgery 1988; 103: 271-77.
3. Flood EP, Redish MH, Bociek SJ, Shapiro S: Thrombophlebitis migrans disseminata: report of a case in which gangrene of the breast occurred; observation on therapeutic use of dicumarol [3,3' methylene bis (4 - hydroxy-coumadin)]. NY State J Med 1943; 43: 1121-4.
4. Grimavdo V, Gueissaz F, Jacques H, Sarrag A, Kruithof E, Bachmann F: Necrosis of skin induced by coumadin in a patient deficient in protein S. Brit Med J 1989; 298: 222-223.
5. Jillson OF: Coumadin-induced necrosis of the skin. Arch Derm 1967, 95: 87-88.
6. Kandrotas RJ, Pharm D, Deterdig J: Genital necrosis secondary to warfarin therapy. Pharmacotherapy 1988; 8: 351-54.
7. Kipin CS: Gangrene of the breast a complication of anticoagulant therapy. New Eng J Med 1961; 256: 638-40.
8. Vaughan ED, Moore RA, Warren H, Moler DN, Gillenwate JY: Skin necrosis of genitalia and warfarin therapy [letter]. JAMA 1969; 210(12): 2283-3.

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Choices, Not Chances:

Teen Health Seminar Attracts Youth Statewide

"Choices, Not Chances," a seminar for teens about today's teen health issues, was held Saturday, November 7, 1992, from 9:00 a.m. to 3:00 p.m. in the Education II Building on the University of Arkansas Medical Sciences Campus.

Ninety-eight students from all areas of the state attended, accompanied by thirty-four counselors, teachers, auxiliary members, and other interested adults.

The seminar was a joint project of the Arkansas Medical Society, the Arkansas Medical Society Auxiliary, and the University of Arkansas School of Medicine.

The Auxiliary State Adolescent Health Committee members who planned the event were: Liz Riley (Mrs. William), AMSA State Health Projects Chair; Rita Rodgers (Mrs. Charles) and Cheryl Pahls (Mrs. Wendall), State Adolescent Health Chairs; Arleta Power (Mrs. Robert), State President-elect of AMSA and AIDS Education Chair; Sandy Harrison (Mrs. William), State President of AMSA; and Nancy Ivy (Mrs. Donald), Intern and Resident Spouse Representative.

Coordinator for the project for UAMS was Dr. Jay Menna, Assistant Dean for Medical Education, School of Medicine. UAMS sponsor for the event was Dr. Dick Wheeler, Associate Dean for Student and Academic Affairs, School of Medicine.

Registration for the event was from 9:00 to 9:30 a.m.

Opening session began at 9:30 a.m. with a welcome by State President Sandy Harrison. Dr. Larry Lawson, State President of the Arkansas Medical Society, addressed the group about the purposes of the Arkansas Medical Society and about some personal experiences in making choices in life and about the profession of medicine. He was accompanied by his daughter Katherine, a law student, and his wife Nikki, a past state president of Arkansas Medical Society Auxiliary.

Dr. Jay Menna, Assistant Dean of Medical Education of the School of Medicine, also spoke to the group about the University of Arkansas School of Medicine and about making good choices in life. He also shared his personal experiences with students.

After the opening session, the students dispersed to separate classrooms for breakout sessions with physician speakers on the following topics:

"Is Safe Sex Really Safe?" - Dr. Karen Kozlowski, UAMS/Arkansas Childrens' Hospital, Pediatric Obstetrician/Gynecologist;

"HIV, STD - Do You Know Your Sex Alphabet?" - Scott Stanley, Junior Medical Student

"Stress Skills for Stress Ills" - Dr. Justin Ternes, Adolescent Psychiatrist, Fayetteville;

"Peak Physique" - Dr. Brian Hardin, Adolescent Wellness Clinic, Arkansas Childrens' Hospital;

"Trust Betrayed" - Dr. Jerry Jones, Children at Risk Department (abused children), Arkansas Childrens' Hospital;

"An Emergency Room Physician's View of Drug and Alcohol Abuse" - Dr. Wendell Pahls, Arkansas Baptist Medical Center Emergency Room.

At lunch break, participants were served Domino's pizza, Jackson cookies, TCBY yogurt and soft drinks. They were entertained at lunch by P.R.I.D.E., a song and dance group from Sylvan Hills High School. The group sings, dances, and performs skits depicting teen problems and positive ways of solving them.

In the afternoon, Miss Arkansas of 1992, Shannon Boy, spoke on "How Do I Get There From Here?" and sang two songs for the group. The message of her talk was reflected in one of her songs titled "I Believe In You." Miss Arkansas was introduced by Willie Oates.

At the end of the day, students turned in evaluation sheets and gave very positive opinions of the seminar. Several students and counselors expressed appreciation for the event and said they found the information very helpful.

Many auxilians from around the state helped with the event by sponsoring and bringing students, by helping with registration, serving lunch, directing students to classes, and by hostessing speakers.

Health exhibits were set up by several agencies in the concourse for students to browse and collect material.

AMS Newsmakers

Dr. James Y. Suen, Chairman of the Department of Otolaryngology in the College of Medicine at UAMS, was listed as one of the 419 best cancer specialists in America in the October issue of Good Housekeeping magazine. The list was obtained through a survey of 350 physicians nationwide.

Dr. B. Eliot Cole, Medical Director for the SeniorCare units at Harris Hospital and Randolph County Medical Center, was part of a delegation of pain management specialists which visited Moscow, Russia and Prague, Czechoslovakia November 2-11. The group toured medical facilities and attended meetings with physicians and academicians from both countries.

Dr. Richard McKelvey, a physician from Clarksville, was recently elected to the board of directors of the American Cancer Society, Arkansas Division.

Dr. Eugene J. Towbin, chief of staff for the VA Medical Center, Little Rock/North Little Rock Divisions, was presented with an Exceptional Service Award by the Department of Veterans' Affairs. Dr. Towbin received the award for his contributions to geriatric medicine.

Dr. Russell D. Degges, Dr. Connie L. Hiers and **Dr. John T. Woloszyn,** physicians from Jonesboro, have been named fellows of the American College of Surgeons.

Dr. Linda Worley, assistant medical director for Youth Home Inc., was awarded first prize in the Resident Award Competition by the American Society for Psychosomatic Obstetrics and Gynecology for her paper titled "Perception of Post-partum Psychiatric Disorders by Primary Care Providers."

Dr. Richard Justiss, a family physician from Pine Bluff, has been named a fellow of the American Academy of Family Physicians. The academy represents 74,000 family physicians and medical students nationally.

Dr. Howard Randall Schmidt, a physician from Texarkana, has been named a fellow of the American College of Surgeons.

Dr. John R. Busby and **Dr. John Lytle,** physicians from Pine Bluff, have been named fellows of the American College of Surgeons, the world's largest organization of surgeons.

Dr. J. William Nuckolls, a Pine Bluff physician and faculty member at UAMS, has been awarded the Robert Shields Abernathy Award for Excellence in Internal Medicine by the Arkansas chapter of the American College of Physicians. Dr. Nuckolls has practiced internal medicine for 18 years.

Dr. Cal R. Sanders, a Ouachita County physician, was elected President of the Ouachita County Medical Society in December. Other newly-elected officers of the Society are: **Dr. Bal Shrestha,** Vice President; **Dr. Robert H Nunnally,** Secretary-Treasurer; and **Dr. Bill Dedman,** Delegate to the Arkansas Medical Society.

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FAYETTEVILLE

Grear, Danna F., Radiology. Born May 31, 1959. Medical education, University of Texas Medical Branch, Galveston, 1985. Internship / residency UTMB, 1989. Board certified.

HOLLY GROVE

Bruce Nichols, Sandra D., Family Practice. Born March 27, 1958. Medical education, UAMS, 1988. Internship / residency, UAMS, 1991. Board eligible.

HOT SPRINGS

Cenac, Joseph W., Jr., Pediatrics. Born January 19, 1954. Medical education, LSU Medical Center, New Orleans, 1979. Internship, Charity Hospital of Louisiana, New Orleans, 1980. Residency, LSU Pediatrics, New Orleans, 1982. Board certified.

JONESBORO

Duke, Billy L., Obstetrics /Gynecology. Born October 13, 1960. Medical education, University of Tennessee College of Medicine, Memphis, 1986. Internship / Residency, UAMS, 1990. Board eligible.

LITTLE ROCK

Berry, Phillip L., Pediatric Nephrology. Born September 12, 1947. Medical education, Baylor College of Medicine, Houston, TX, 1974. Internship, Baylor Affiliated Hospitals, Houston, 1975. Residency, Baylor Affiliated Hospitals, Children's Mercy Hospital, 1977. Board certified.

Brown, Raeford E., Jr., Pediatric Anesthesia. Born February 18, 1954. Medical education, University of North Carolina School of Medicine, Chapel Hill, 1980. Internship / Residency, Children's Hospital National Medical Center, Washington, D.C., 1983. Residency, University of Virginia Medical Center, Charlottesville, 1985. Board certified.

Harrell, James E., Jr., Thoracic and Cardiovascular Surgery. Born September 21, 1953. Medical education, Baylor College of Medicine, Houston, TX, 1978. Internship, John Hopkins Hospital, Baltimore, MD, 1979. Residency, John Hopkins Hospital / University of Texas at Houston, 1984. Board certified.

RESIDENTS

Fiser, Richard T., Pediatrics. Born August 24, 1965, Little Rock, AR. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1991. Internship/Residency, UAMS.

Hadjari, Minoo H., Orthopaedics. Born December 29, 1960, Tehran, Iran. Medical education, University of Nevada School of Medicine, Reno, NV, 1984. Residency, UAMS.

Cheng, Richard Z. Born December 24, 1959. Medical education, Shanghai Medical University, Shanghai, China, 1982. Residency, Shanghai Medical University. Internship, Shanghai Medical University / UAMS.

Kelly, Kathleen A. Born August 26, 1956. Medical education, UTHSCSA, San Antonio, TX, 1992. Internship, UAMS.

Neal, Marianne R., Radiology. Born February 17, 1965. Medical education, UAMS, 1991. Residency, UAMS.

Scott, Carla R., Pediatrics. Born August 9, 1963. Medical education, UAMS, 1991. Internship / residency, Arkansas Children's Hospital.

Wormuth, Christopher J., Neurosurgery. Born November 15, 1966. Medical education, Pennsylvania State College of Medicine, Hershey, 1992. Internship / Residency, UAMS.

Sharma, Ranbir K., Pediatrics. Born July 17, 1965. Medical education, University of Texas Medical Branch, Galveston, 1991. Internship / Residency, Arkansas Children's Hospital.

Minton, Randy. Born May 2, 1965. Medical education, UAMS, 1992. Internship, UAMS.

Rayburn, John M., Emergency Medicine. Born April 9, 1965. Medical education, UAMS, 1990. Internship / Residency, UAMS.

Garner, Dewey D., Radiology. Born April 5, 1965. Medical education, University of Mississippi Medical Center, Jackson, 1991. Residency, UAMS.

Willis, Charlotte R., Pediatrics. Medical education, Louisiana State University Medical School, Shreveport, 1990. Internship / Residency, Arkansas Children's Hospital.

Pfitzner, Mark A., Pediatrics. Born September 30, 1964. Medical education, University of Missouri, Columbia, 1991. Internship / Residency, Arkansas Children's Hospital.

Spanos, Demetrius, Neurology. Born August 25, 1960. Medical education, St. Georges University School of Medicine, Grenada, 1990. Internship, Christ Hospital and Medical Center, Oak Lawn, IL. Residency, UAMS.

Crotts, Martha E., Psychiatry. Born September 21, 1964. Medical education, Southern Illinois University, Springfield, 1991. Internship / Residency, UAMS.

Mehta, Madhu, Internal Medicine. Born September 1, 1960. Medical education, Maulana Azad Medical College, New Delhi, India, 1985. Internship, Maulana Azad Medical College. Residency, Michigan State University, Lansing / UAMS.

Henry, Ronda S., Surgery. Born February 2, 1962. Medical education, University of California, San Diego, 1992. Internship/Residency, UAMS.

Ferrer, Thomas J. Born January 22, 1965. Medical education, Washington University, St. Louis, MO, 1991. Internship, Washington University, Barnes Hospital. Residency, UAMS.

Anthony, John L., Dermatology. Born May 24, 1964. Medical education, UAMS, 1991. Internship / Residency, UAMS.

Lowther, Laura M., Pathology. Born November 24, 1965. Medical education, Louisiana State University, Shreveport, 1991. Residency, UAMS.

Calderon, Vince, Pediatrics. Born April 22, 1960. Medical education, University of Texas Medical Branch, Galveston, 1990. Internship / Residency, Arkansas Children's Hospital.

Smoot, Ernest A., Jr., Pediatrics. Born May 29, 1958. Medical education, University of Texas Southwestern Medical School, Dallas, 1991. Internship / Residency, Arkansas Children's Hospital.

MEDICAL STUDENTS

Simmons, John R.
Shaw, Robert H.
Davis, Donna L.
Wofford, Scott A.
Fant, Jerri S.
Smith-Mitchel, Daniel F.
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AIR FORCE

In Memoriam

Jewel Ann Ashley

Jewell Ann Ashley, of Newport, a journalist, died Saturday. She was 65.
Mrs. Ashley is survived by her husband, Dr. John D. Ashley Jr.; a son, Thomas D. Ashley of Buffalo, Texas; a sister, Judy Price Eby of Lafayette, Louisiana; six grandchildren and seven great-grandchildren.

Robert H. Robbins, M.D.

Robert H. Robbins, M.D., of Mountain Home, died Monday, December 21, 1992. He was 82.
Survivors are his wife, Rachel Robbins of Mountain Home; a son, Michael C. Robbins of Columbia, Missouri; a daughter, Patricia Jacobs of Waukegan, Illinois; five grandchildren and five great-grandchildren.

John D. Smoot, M.D.

John D. Smoot, M.D., of Pocahontas, died Saturday, December 12, 1992. He was 63.
Survivors are a son, Charles R. Smoot of Pocahontas; a daughter, Betty Gray Duncan of Seattle; and a brother, Alex Smoot of Minneapolis.

Charles Henderson Weber, M.D.

Charles Henderson Weber, M.D., of Magnolia, died Saturday, December 19, 1992. He was 54.
Dr. Weber is survived by his wife, Carole Clark Weber of Magnolia; two sons, Charles Weber of Little Rock and Scott Weber of Fayetteville; a daughter, Kimberly Parham of Little Rock; his mother, Anne Weber of Magnolia, two brothers, Mike Weber of DeSoto, Missouri and Dr. Pat Weber of Texarkana, Texas; a sister, Charlann Reaves of Russellville; and a grandchild.

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Health Care Access Foundation Update

As of January 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 5,221 medically indigent persons, received 10,778 applications, and enrolled 22,222 persons.

The programm has 1,488 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

Burlex Oncology Foundation Begun

Dumont, N.J. - The Board of Trustees is pleased to announce the formation of the Berlex Oncology Foundation, a non-profit organization dedicated to the support of education and clinical research in the field of oncology.

"The Foundation's stated objective is to elevate the quality of clinical research in oncology to the highest level possible and to encourage young physicians to enter the field," states Robert C. Young, M.D., Chairman of the Board of Trustees. The group's initial efforts will focus on senior fellows or junior faculty in their fourth or fifth years of oncology training. "We hope to be able to encourage young physicians in their transitional years to continue to pursue a career course that will ultimately result in their becoming academicians and clinical investigators," said Dr. Young.

Three major programs will be initiated in 1993: 1) an oncology fellowship to fund clinical investigation for a 2-year period. 2) a comprehensive course in clinical trial design, methodology, epidemiology and statistics; and 3) an oncology-specific course focusing on clinical pharmacology and therapeutics.

Joining Dr. Young on the Board of Trustees are: Jonathan Berek, M.D. of UCLA; Clara Bloomfield, M.D. of Roswell Park Cancer Institute, Buffalo; George Canellos, M.D. of the Dana-Farber Cancer Institute, Boston; Ronald Castellino, M.D. of Memorial Sloan-Kettering Cancer Center; C. Norman Coleman, M.D. Harvard Medical School; Paul Engstrom, M.D. of Fox Chase Cancer Center, Philadelphia; Brian Henderson, M.D. of the University of Southern California; Evan Hersh, M.D. of the University of Arizona Cancer Center; John Niederhuber, M.D. of Stanford University Medical Center; Joseph Simone, M.D. of Memorial Sloan-Kettering Cancer Center; and E. Donnall Thomas, M.D. of the Fred Hutchinson Cancer Center. The Foundation will be administered by the Center for Bio-Medical Communication, Inc.

Basketball Tournament for Doctors Held

On December 6, 1992, at Mount St. Mary's gymnasium, a basketball tournament for doctors was held. Twenty-five doctors participated in a three-on-three half-court tournament. The winning team consisted of Duane Velez from The Family Practice Clinic, a gastroenterologist, David Hicks, a family practitioner from The Family Practice Clinic, and Kenneth Collins, a chief resident in medicine at the University of Arkansas. They were awarded new basketballs, in lieu of a trophy.

If interest is shown in repeating this tournament, it will be held again in 1993. It is hoped that more teams from around the state will participate in the future. Contact Arkansas Cardiovascular Surgery Associates if interested, at 224-5666.

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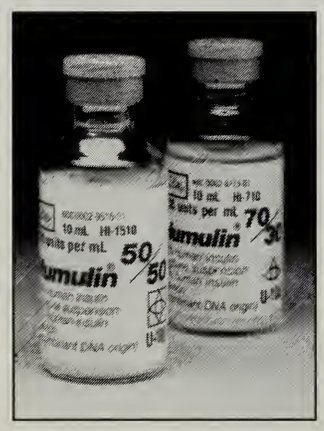

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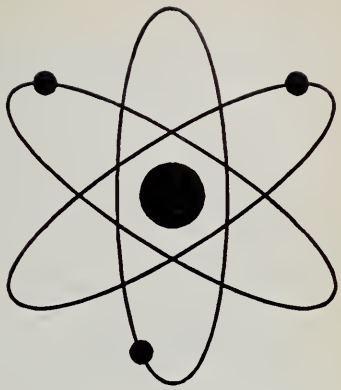
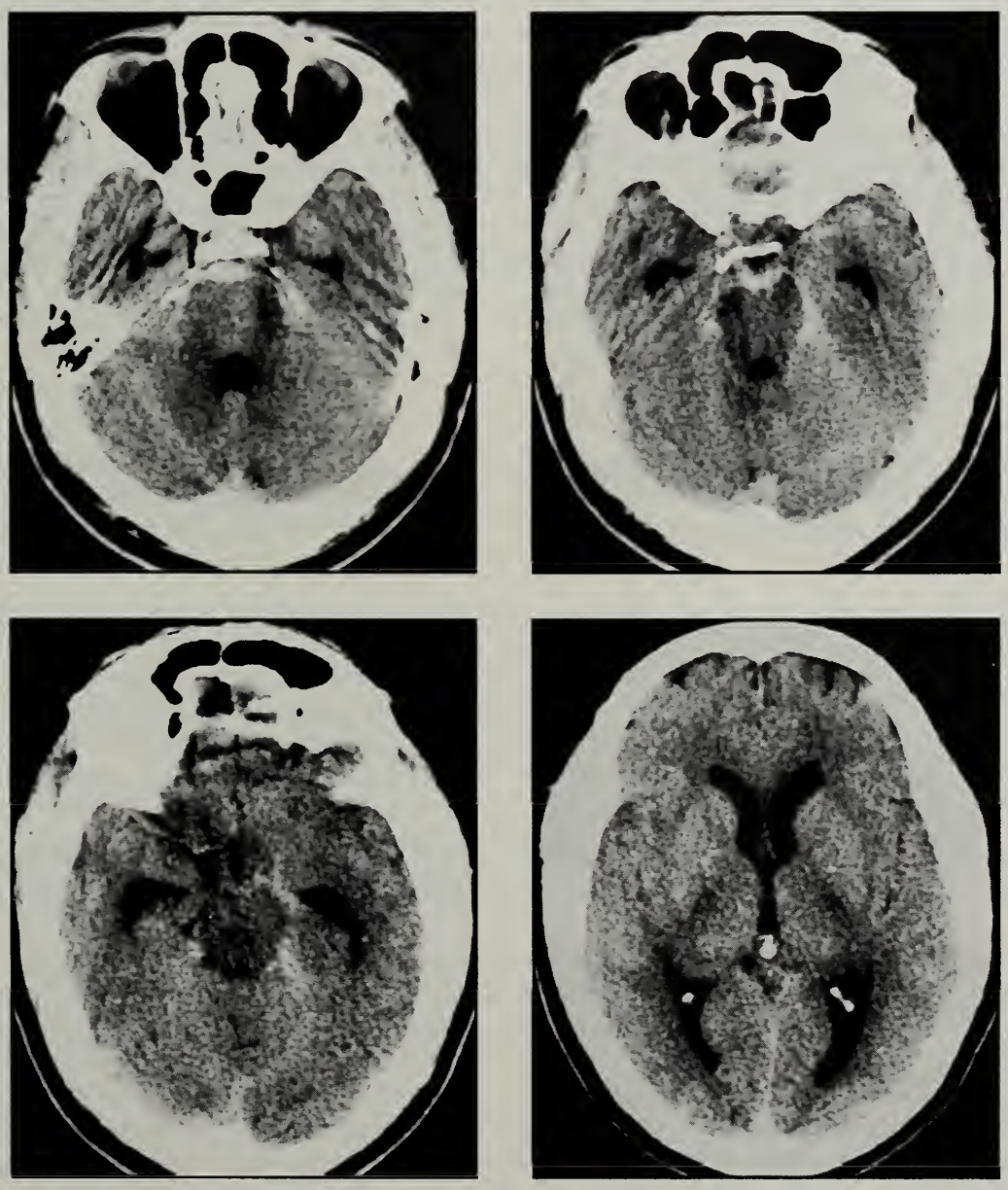
Radiological Case of the Month



Steven R. Nokes, M.D.
W. Bradley Pierce, M.D.
David L. Reding, M.D.
Doyne Dodd, M.D.

History:

A fifty-year-old male presented with abrupt onset of headache and neck rigidity without a history of trauma. Four images from a noncontrast CT scan of the head are shown. What is the most likely cause of this patient's subarachnoid hemorrhage?



Figures 1-4/ Noncontrast CT scan of the head.

Nonaneurysmal perimesencephalic subarachnoid hemorrhage.

Findings:

The images reveal high density acute subarachnoid blood in the interpeduncular fossa, with extension of blood into both ambient cisterns and the prepontine cistern. There is no blood in the anterior interhemispheric or lateral sylvian fissures. No intraventricular extension is evident.

Discussion:

Subarachnoid hemorrhage (SAH) is the hallmark presentation of small "berry" aneurysms. These commonly present in patients 40 to 50 years old. Seventy-five percent of adults with nontraumatic SAH have a demonstrable aneurysm by angiography; 10 percent have an AVM; approximately 15 percent have no demonstrable cause of bleeding, despite high-quality four-vessel angiography.

The distribution of extravasated blood on CT scans in patients with SAH is helpful in predicting the site of the aneurysm. Classically, basilar artery aneurysms are associated with blood in the prepontine and posterior suprasellar cistern, but this distribution has recently been shown to be characteristic of nonaneurysmal perimesencephalic hemorrhage (Figure 5). Angiography should not be omitted, as 5% of basilar aneurysms can have a similar pattern of SAH.

The cause of perimesencephalic hemorrhage is felt to be venous or capillary rupture, rather than an undetected aneurysm. These patients have a benign course without rehemorrhage or ischemia, whereas basilar artery aneurysms carry a fatal rehemorrhage risk of 50% in the first four years following the initial bleed. Eventually, awareness of this CT pattern may obviate angiography in these patients.

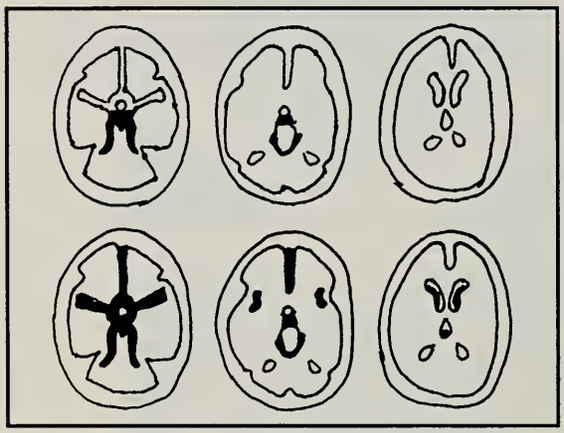


Figure 5. Line drawing showing characteristic pattern of blood distribution in nonaneurysmal perimesencephalic hemorrhage (upper row) and characteristic pattern of SAH from a ruptured basilar artery aneurysm (bottom row).

References:

Rinkel GJE, Wijdicks EFM, Vermeulen M, et al. Nonaneurysmal perimesencephalic subarachnoid hemorrhage: CT and MR patterns that differ from aneurysmal rupture. AJR 1991; 157:1325-1330.

Alexander MSM, Dias PS, Uttley D. Spontaneous subarachnoid hemorrhage and negative cerebral panangiography. J. Neurosurg 1986; 64:537-542.

Iwanaga H, Wakai S, Ochai C, et al. Ruptured cerebral aneurysms missed by initial angiographic study. Neurosurgery 1990; 27:45-51.

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Things To Come

February 17

Modern Usage of Anti-Infectives. Hyatt Regency Hotel, Kansas City, MO. Sponsored by the Department of Internal Medicine-Division of Infectious Disease, University of Kansas Medical Center. CME accreditation offered. For more information, call (913) 588-4488.

February 20

Cardiology for the Primary Physician. University of California-Davis Medical Center, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California-Davis School of Medicine and Medical Center. Fees: $90 physicians, $70 others. CME accreditation offered. For more information, call (916) 734-5390.

February 21-26

Emergency Medicine. Hyatt Regency, Incline Village (North Lake Tahoe), NV. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. Fees: $425/$325, past participant; $465/365, non-past participant. CME accreditation offered. For more information, call (916) 734-5390.

February 25-28

11th Annual International Symposium on Man and His Environment in Health and Disease. Southland Center Hotel, Dallas, TX. Sponsored by the American Environmental Health Foundation. CME credit offered. For more information, call Laura Gibson (214) 373-5164 or Sally Smith (214) 373-5161.

February 27

Women and Men in Health Care. Washington University Medical Center, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. 7.5 credit hours AMA Category I and 8.4 contact hours MONA. For more information, call (800) 325-9862.

March 3-4

Pan-American Symposium on AIDS and HIV Disease: A Mental Health Perspective. San Juan, Puerto Rico. Sponsored by the American Psychiatric Association. For more information, call (202) 682-6143.

March 6-11

20th Annual Critical Care Medicine Course. Oklahoma City Marriott Hotel. Sponsored by the Department of Medicine, College of Medicine, The University of Oklahoma Health Sciences Center and the Veterans Affairs Medical Center in conjunction with the Office of Continuing Medical Education. Fees: $650. CME accreditation offered. For more information, contact Dora Lee Smith at (405) 271-5904.

March 6-13

Update in Clinical Medicine. Vail, Colorado. Sponsored by The George Washington University Medical Center Office of Continuing Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

March 8-12

Radiation Safety Specialist Training Program. Oklahoma City, OK. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

March 10-13

Health Care '93. Sunshine City Exhibition Center, Ikeburuko, Tokyo. Sponsored by JETRO (Japan External Trade Organization). For more information, call JETRO-Houston (713) 759-9595.

March 12-13

6th Annual Clinical Nutrition Conference. Berkeley Marina Marriott, Berkeley, CA. Sponsored by the Office of Continuing Medical Education, University of California Davis School of Medicine and Medical Center. CME accreditation offered. Fees: $225 physician; $155 dietitian. For more information, call (916) 734-5390.

March 13

Women's Health and Breast Cancer. University of California, Davis, Medical Center, Cancer Center Auditorium, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the UC, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

March 15-17

Lake Tahoe Annual Vascular Conference. Olympic Village (Squaw Valley), CA. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

March 18

14th Annual What's New in Diabetes Symposium. Adam's Mark Hotel, Kansas City, MO. Sponsored by the University of Kansas Medical Center-Department of Internal Medicine and Cray Diabetes Center, in cooperation with the American Diabetes Association. CME accreditation offered. For more information, call (913) 588-7108.

March 18-19

Gastrointestinal Surgery: Refresher Course and Update. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. 14 credit hours AMA Category I offered. For more information, call (800) 325-9862.

March 18-20

Spring Break for CME. PGA National Resort & Spa, Palm Beach Gardens, FL. Sponsored by the Florida Medical Association. CME accreditation offered. Fees: $385. For more information, call (904) 356-1571.

March 25-27

Laboratory Workshop in Breast Reconstruction. Sentara Norfolk General Hospital, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 2-3

Ambulatory Pediatrics. Sacramento Inn, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

5th Annual Rae R. Jacobs Memorial Lecture: Back Pain. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the University of Kansas Medical Center-Department of Surgery, Section of Orthopedic Surgery. CME accreditation offered. For more information, call (913) 588-4488.

Fighting for Their Lives: You Can Make A Difference - HIV Update. Cancer Center Auditorium, UC Davis Medical Center, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

April 8-9

Hands-On Workshop on Advanced Diagnostic Methods in Andrology. Jones Institute of Reproductive Medicine, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 16-18

43rd Annual Postgraduate Symposium on Anesthesiology. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the Department of Anesthesiology, the University of Kansas Medical Center. CME accreditation offered. For more information, call (913) 588-4488.

April 18-20

13th Annual Meeting of the American Society for Laser Medicine and Surgery. Marriott Hotel, New Orleans, LA. CME accreditation offered. For more information, call (715) 845-9283.

First Annual Update Course in Gynecology. Grand Hyatt Hotel, New York, NY. 13.5 hours Category I CME credit offered. A reduced tuition fee of $445 will be offered through March 1. For more information, call (201) 385-8080.

April 21-25

Seventh Annual Critical Care Update. Hyatt Regency-Capitol Hill, Washington, D.C. 35 hours Category I CME credit offered. For more information, call (201) 385-8080 or (800) 231-0389.

April 23

Thrombolysis: Its Role in Peripheral, Arterial and Venous Disorders. Omni International Hotel, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 23-24

5th Annual Pediatrics & All That Jazz: Current Practice and Recent Advances. Brent House Hotel, New Orleans, LA. Sponsored by the Alton Ochsner Medical Foundation, New Orleans. For more information, call (504) 842-3702.

29th Annual Orthopaedic Symposium - Diagnosis and Treatment of Diseases of the Cervical Spine.

The Houstonian Hotel and Conference Center, Houston, TX. Sponsored by St. Luke's Episcopal Hospital. For more information, call (713) 791-4200.

April 24

Hemodynamic Monitoring in Anesthesia and Intensive Care. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. 6.5 credit hours AMA Category I offered. For more information, call (800) 325-9862.

April 26-30

Radiation Safety Instrumentation & Compliance. Sheraton Plaza Hotel, Orlando, FL. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

April 29-May 1

12th Annual Conference on Child Abuse and Neglect. Red Lion Inn, Sacramento, California. Sponsored by Office of Continuing Medical Education, University of California-Davis School of Medicine and Medical Center. 12 hours Category I CME credit offered. For more information, call (916) 734-5390.

19th Annual Meeting of the Federated Ambulatory Surgery Association. Sheraton Harbor Island Hotel, San Diego, CA. For more information, call (703) 836-8808.

April 29-May 2

Clinical Electrocardiography: Basic Concepts & Interpretation - 13th Edition. Ritz-Carlton Hotel, Philadelphia, PA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 30-May 1

Hearing Aid Conference. Frontenac Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

April 30-May 2

Pathology of HIV. Arlington, VA. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, (202) 992-4285.

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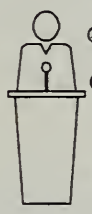
Don't miss the chance to get away and have some fun while you attend the Arkansas Medical Society annual convention!!

Golf Tournament for Members and Exhibitors on Thursday morning ◆ Welcome reception on Thursday afternoon, followed by the 1st House of Delegates ◆ Blue Cross Blue Shield Reception on Thursday evening ◆ Shuffield Luncheon on Friday at noon ◆ A Western Hoedown on Friday evening ◆ Exhibits and CME Sessions on Thursday and Friday ◆ The Final House of Delegates on Saturday morning ◆ Derby Day at Oaklawn on Saturday afternoon ◆ The AMS Inaugural Banquet on Saturday evening, followed by the President's Reception.



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Keeping Up

Peripheral Vascular Disease

March 20, 1993, time to be announced, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine. Dr. Robert Barnes and Dr. Ernest Ferris will present the program, which is entitled "Concepts and Management of Peripheral Vascular Disease." 5.5 hours Category I credit offered.

Infectious Disease Update

April 2 & 3, 7:30 a.m. - 12 noon, The Park Hilton, Hot Springs. Sponsored by Arkansas Children's Hospital, Department of Pediatrics/UAMS. CME Category I credit available. Fee: $100.

Family Medicine Spring Academic Conference

May 21-23, 1993, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

Cancer Conference

February 1, 8, 15, 22, and March 1, 8, 15, 22, 23, 29, 12:15 p.m., St. Joseph's Regional Health Center, Hot Springs, Conference Dining Room #1. Sponsored by St. Joseph's Regional Health Center. One hour of Category I credit offered.

Chest Conference

March 23, 12:15 p.m., St. Joseph's Regional Health Center, Hot Springs, Conference Dining Room #1. Sponsored by St. Joseph's Regional Health Center. Presented by Robert Johnson, M.D. and Naomal Jaysundera, M.D. One hour of Category I credit offered.

Arkansas Society of Anesthesiologists Meeting

April 3, 1993, 7:45 a.m. - 4:45 p.m., Holiday Inn West, Little Rock. Sponsored by UAMS Department of Anesthesiology. Topic: "Obstetrics Anesthesia Update," presented by Richard Clark, M.D. Call (501) 686-6125 for more information.

Office Laboratory Seminar

February 27, Holiday Inn West, Little Rock. Sponsored by the Arkansas and American Academies of Family Physicians. Fee: $125. CME credit offered. For more information, contact the Arkansas AFP at (501) 223-2272 or the American AFP at (800) 274-2237, ext. 5440.

Critical Care Medicine

April 1-3, 1993, 7:00 a.m., Arlington Hotel, Hot Springs. Sponsored by UAMS College of Medicine and presented by Jeffrey Brent Bond, M.D., John B. Cone, M.D., Loren Crown, M.D. 11.5 hours Category I credit are offered. Fee - $200.

UAMS College of Medicine Alumni Weekend

June 11-13, 1993. Capital and Excelsior Hotels, Little Rock. Sponsored by the Arkansas Caduceus Club, College of Medicine Alumni Association. For more information, call (501) 686-6684.

46th AAFP Annual Scientific Assembly

July 29-August 1, 1993, Excelsior Hotel and Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER
CME Luncheon for Medical/Dental Staff, February 12 & 26, March 12 & 26, 12:30 p.m., AMI Ozark/Quapaw room. One hour Category I credit per luncheon.

FAYETTEVILLE-VA MEDICAL CENTER
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL
Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER
Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL
Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room
Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room
Tumor Conference, 1st Thursday, 12:00 noon, Assembly room
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room

LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, 4th Thursday, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Pre-op/Didactic Conference, Mondays, 5:00 p.m., VAMC-LR, 4D
Urology Radiology Conference, 1st Thursday, 5:00 p.m., UAMS, Radiology Department
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Urology VA Teaching Rounds, every Friday, 7:30 a.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO-AHEC
Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas

Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC - South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

FAYETTEVILLE-AHEC NORTHWEST
AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH-AHEC
Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST
AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC
Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST
Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N=900)	Placebo (N=411)	Pravastatin (N=900)	Placebo (N=411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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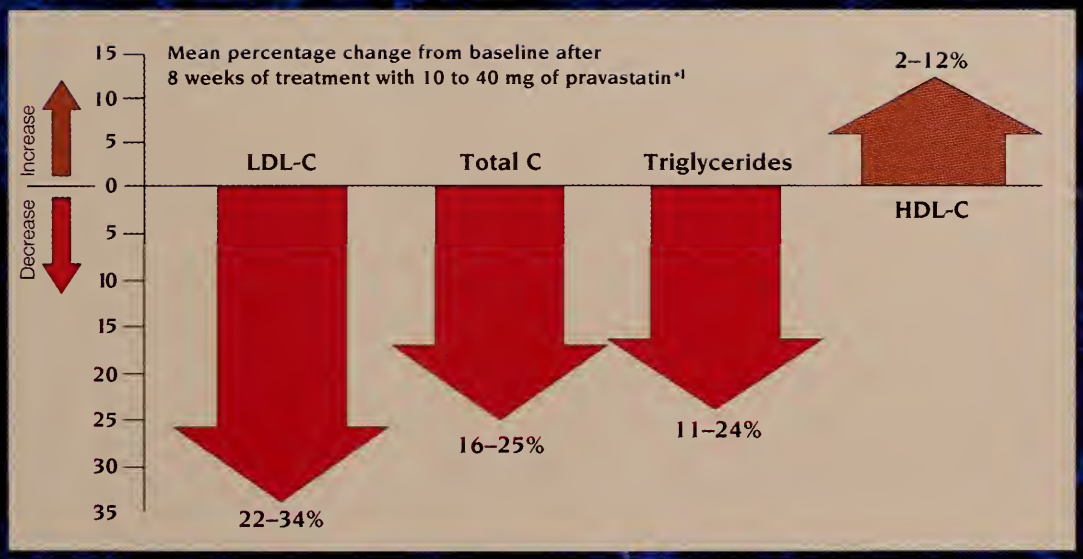
Effective cholesterol control

Consistently and significantly reduces total C and atherogenic LDL-C; positively affects other key lipids



*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease *or* unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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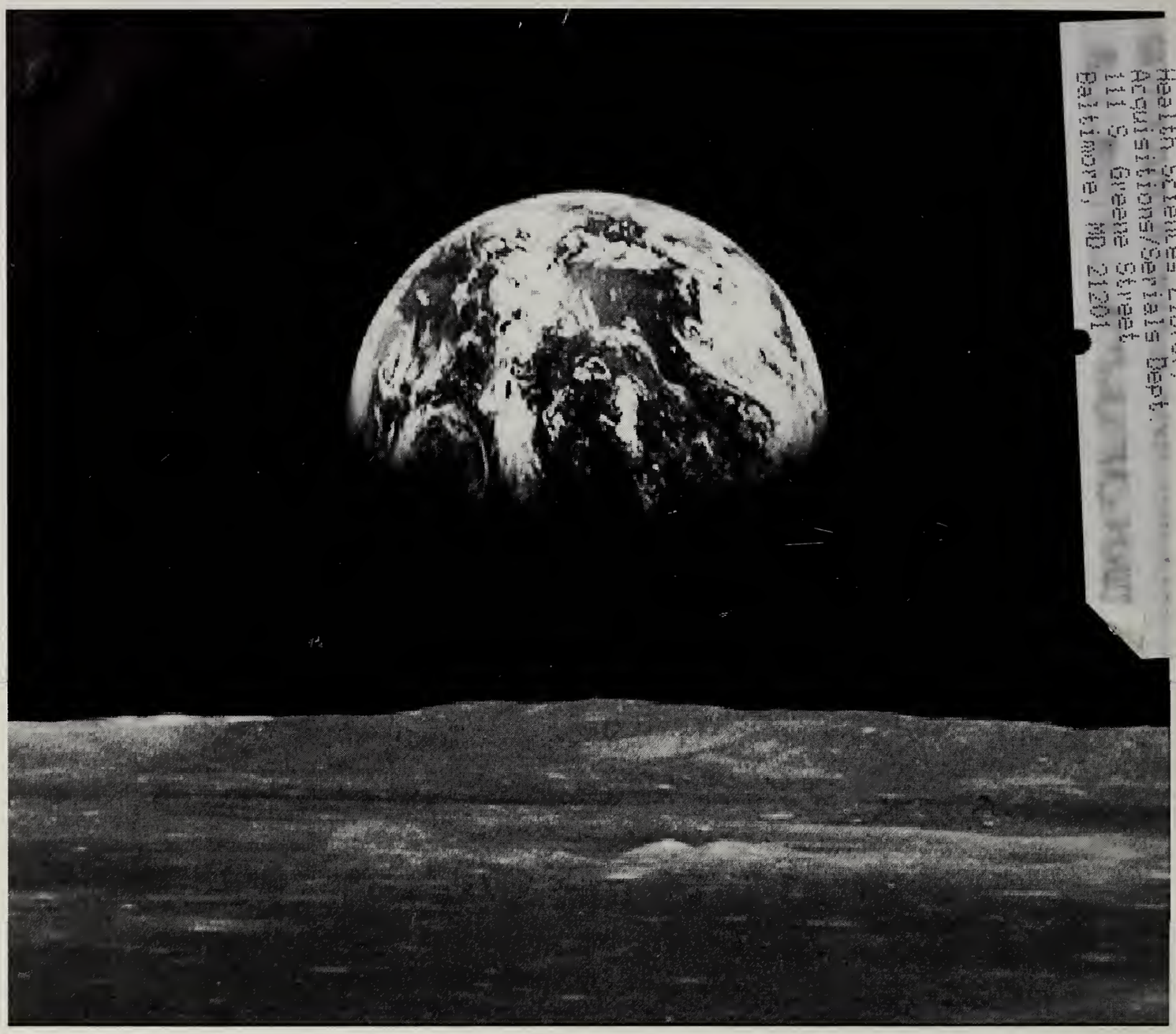

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 89 Number 10 March 1993

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117th Annual Session

Arkansas Medical Society
Arlington Hotel ⊙ Hot Springs
April 15-17, 1993

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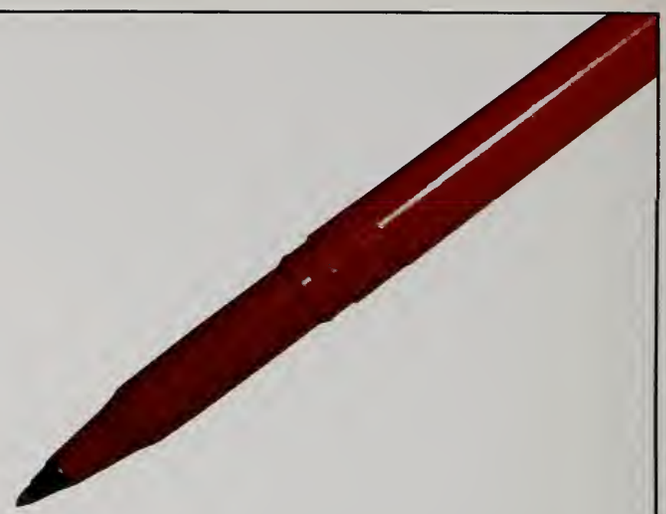

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 89 Number 10 *March 1993*

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Cover photos by A. C. Haralson, Arkansas Dept. of Parks & Tourism.

DOCTOR'S DAY

Thank you, Arkansas' Doctors!

To show our appreciation for the medical care you've shown the people of Arkansas, the following hospitals and medical auxiliary and society members have contributed to the American Medical Association Education & Research Foundation, in celebration of Doctor's Day, March 30, 1993.

Facilities

Dardanelle Hospital
Medical Center of South Arkansas, El Dorado

Auxiliary & Society Members

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Dr. & Mrs. Dana P. Rabideau
Dr. & Mrs. Don Riley
Mrs. J. P. Price
Doctors Charles and Reid Henry
Dr. & Mrs. Charles H. Rodgers
Dr. Joseph Walter Ledbetter
Mrs. Robert Langston
Dr. James D. Pickett
Mary Jo Mizell
Dr. & Mrs. Robert C. Power
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Dr. & Mrs. James G. Burgess

The Arkansas Medical Society Auxiliary

Arkansas Medical Society

"ON THE RIGHT TRACK"

1993 CONVENTION REGISTRATION

117TH ANNUAL SESSION • APRIL 15 - 17, 1993
ARLINGTON HOTEL • HOT SPRINGS, ARKANSAS

On the Right Track

1993 AMS Convention Program

Arlington Hotel Hot Springs, Arkansas April 15 - 17, 1993

Thursday, April 15, 1993

9:00 a.m.
Golf Tournament
Sponsored by Schering Corporation

1:00 p.m. - 5:00 p.m.
Registration

2:30 p.m.
Council Meeting

3:30 p.m.
Welcome Reception
1st Exhibit Time
Sponsored by Worthen National Bank of Arkansas

5:00 p.m.
House of Delegates
Speaker to be announced

6:30 p.m.
Blue Cross Blue Shield Reception
By the Pool Deck - Dress is Casual

Friday, April 16, 1993

7:30 a.m. - 4:30 p.m.
Registration

7:30 a.m.
Council Meeting

8:00 a.m.
Continental Breakfast
2nd Exhibit Time

10:00 a.m.
Reference Committees

11:00 a.m.
"The Effect of CLIA on Your Practice"
Paul Bachner, M.D.
Department of Pathology and Laboratory Medicine
United Hospital Medical Center
Port Chester, New York

12:30 p.m.
Shuffield Luncheon/Lecture
Lecture sponsored by State Volunteer Mutual Insurance Company

2:15 p.m.
Second Socio-economic Session
Speaker to be announced

3:30 p.m.
Afternoon Break
3rd Exhibit Time
Grand Prize for AMS members sponsored by Tours & Travel of Russellville

6:30 p.m.
Western Hoedown
Entertainment: KSSN Bandits - Dress is Casual
Sponsored by Freemyer Collection System and American Health Care Providers, Inc.

Saturday, April 17, 1993

7:30 a.m. - 11:00 a.m.
Registration

7:30 a.m.
Council Meeting

8:00 a.m.
Early Morning Refreshments

8:45 a.m.
"Universal Health Care - The Minnesota Plan"
The Honorable Paul Anders Ogren
Minnesota State Representative
President, State Alliance for Universal Health Care
Saint Paul, Minnesota

10:30 a.m.
House of Delegates

11:30 a.m.
Fifty Year Club Luncheon

12:30 p.m.
Open for Derby Day at Oaklawn, shopping or other recreational activities. Specialties can elect to meet.

7:30 p.m.
Inaugural Banquet

9:00 p.m.
President's Reception

69th Auxiliary Annual Session Program

Arlington Hotel Hot Springs, Arkansas

April 15 - 17, 1993

Thursday, April 15, 1993

1:00 p.m. - 5:00 p.m.
Registration

2:00 p.m.
Pre-Convention Board Meeting

4:00 p.m. - 5:00 p.m.
Welcome Reception
1st Exhibit Time
Sponsored by Worthen National Bank of Arkansas

6:30 p.m.
Blue Cross Blue Shield Reception
By the Pool Deck - Dress is Casual

Friday, April 16, 1993

7:30 a.m. - 4:30 p.m.
Registration

8:00 a.m.
Continental Breakfast
2nd Exhibit Time

Past President's Breakfast

9:00 a.m.
Opening General Session
Sandy Harrison, President, presiding
General Business, Roll Call and Seating of Delegates
Mrs. Barbara Tippins, Field Director
American Medical Association Auxiliary
Mrs. Mildred Taylor, President-elect
Southern Medical Association Auxiliary
J. Larry Lawson, M.D., President
Arkansas Medical Society
Mr. Ken LaMastus, Executive Vice President
Arkansas Medical Society
Ms. Kay Waldo, Director of Administrative Services
Arkansas Medical Society
Address
Mrs. Barbara Tippins
Convention Announcements
Kay Borg and Laura Larrison, Convention Chairmen
Reports of Officers and Committee Chairmen
Unfinished Business
New Business
Election of the Nominating Committee for 1993-1994
(2 from the Board; 2 from the House of Delegates)
Election of Delegates and Alternates to the 1993
AMA Auxiliary Convention, Chicago
Presentation of the 1993-1994 Budget
Mrs. Sandra Lyons, Finance Chairman

12:30 p.m.
Shuffield Luncheon/Lecture
Lecture sponsored by State Volunteer Mutual
Insurance Company

2:30 p.m.
Reconvene General Session

6:30 p.m.
Western Hoedown
Entertainment: KSSN Bandits - Dress is Casual
Sponsored by Freemyer Collection System and
American Health Care Providers, Inc.

Saturday, April 17, 1993

7:30 a.m. - 10:00 a.m.
Registration

8:30 a.m.
Second General Session
Mrs. Sandy Harrison, President, presiding
General Business
Greetings from Southern
Mrs. Mildred Taylor
Reports by County Presidents
Moderators: District Vice Presidents
Unfinished Business
New Business
Nominating Committee Report
Mrs. Rita Rodgers
Election of Officers
Adjournment

10:00 a.m.
AMSA Installation Brunch
Mrs. Sandy Harrison, President, presiding
Presentation of Awards
Installation of Officers
Mrs. Barbara Tippins
Adjournment
Afternoon is open for Derby Day or other recreation.

7:30 p.m.
AMS Inaugural Banquet

9:00 p.m.
AMS President's Reception

General Information

Registration and Fees

The convention registration desk will be located on the mezzanine of the Arlington Hotel and will be staffed during the following times:

Thursday, April 15	1:00 p.m.	- 5:00 p.m.
Friday, April 16	7:30 a.m.	- 4:30 p.m.
Saturday, April 17	7:30 a.m.	- 11:00 a.m.

No person will be admitted to any activity of the annual session without first registering. Upon checking in at the convention registration desk, you will receive a convention program, your name badge, tickets for meals and social functions, and other convention material.

	Pre-registration	On-site Registration
Member	$75.00	$90.00
Non-member	$110.00	$125.00
Spouse	$55.00	$70.00
Residents	$5.00	$10.00
Students	$5.00	$10.00

AMS Past Presidents receive $25.00 discount

Telephone Service

The Society will have a convention telephone at the registration desk during registration hours for your convenience. Call the Arlington Hotel operator at (501) 623-7771 and ask for the Arkansas Medical Society registration desk on the mezzanine. You may leave this number with your office personnel in case of emergencies.

Hotel Reservation Information

Call the Arlington Resort Hotel & Spa at (501) 623-7771. Be sure to tell them that you are with the Arkansas Medical Society meeting to be held April 15 - 17, 1993.

Cancellation Policy

All cancellations must be made in writing and received by March 31, 1993 to receive a refund. No refunds will be given after that date. All refunds, minus a $10 processing fee, will be mailed after the conference. No refunds will be given on site.

Exhibits

Commercial and scientific exhibits will be on display in the Arlington Exhibit Center. They will be open during the following times:

Thursday, April 15	3:30 p.m.	- 5:00 p.m.
	8:00 a.m.	- 10:00 a.m.
Friday, April 16	3:30 p.m.	- 5:00 p.m.

The Annual Session Committee urges all members and their guests to take the time to visit the displays. The exhibits are a part of the educational program of the convention and provide members with the latest information on progress in pharmaceutical research, developments in instruments and equipment, insurance, accounting systems, computers, investments, and other new products and services available.

The exhibits represent an important contribution to the convention. You are urged to visit each booth and let the exhibitors know you appreciate their participation.

Convention Officials

AMS President
J. Larry Lawson, M.D., Paragould

AMS President-elect
Glen F. Baker, M.D., Little Rock

AMS Auxiliary Convention Chairman
Mrs. Kay Borg, Hot Springs

AMS Auxiliary Convention Co-Chairman
Mrs. Laura Larrison, Hot Springs

Blue Cross Blue Shield Reception

By the Pool Deck
Thursday, April 15 at 6:30 p.m.

117th Annual Session • Arlington Hotel • Hot Springs

Convention Registration Form

Dr. _____
(Please Print)

Mr./Mrs. _____
(First and Last Name)

Address _____

City _____ State _____ Zip _____ County _____

Adopt-a-Doctor Discount

Take $25.00 off your registration fee if you bring a physician who has never attended (or if you have never attended) an AMS Annual Session. Your "Adopted Doctor" is:

_____ of _____
(Name) (City)

Registration Information

AMS Member and Spouse fees cover: Shuffield Luncheon, Inaugural Banquet, Continental Breakfast, Exhibit Center Breaks, and entrance into the Exhibit Center. Auxiliary fees cover: Installation Brunch

No one will be allowed in the Exhibit Center without a registration badge.

REGISTRATION FEES

	PRE-PAID	ON-SITE
Member	$75.00	$90.00
Non-Member	$110.00	$125.00
Spouse	$55.00	$70.00
Resident	$5.00	$10.00
Medical Student	$5.00	$10.00
Auxiliary Brunch	$20.00	$25.00

AMS Past Presidents receive $25.00 discount.

FOR APPROPRIATE MEAL COUNT, PLEASE INDICATE NUMBER ATTENDING:

_____ # Attending Shuffield Luncheon

_____ # Attending Inaugural Banquet

_____ # Attending Auxiliary Installation Brunch

TOTAL AMOUNT ENCLOSED: _____

Checks for member, spouse, and auxiliary registration should be forwarded with the registration form and made payable to **Arkansas Medical Society, P.O. Box 5776, Little Rock, AR 72215-5776.** If you have any questions, please call 224-8967 (in Little Rock) or 1-800-542-1058. Cancellations must be made in writing and received by March 31st to receive a refund. All refunds, minus a $10.00 processing fee, will be mailed after the session.

Other Meetings

Fifty Year Club Luncheon

The Society will host a luncheon for members of the Fifty Year Club at 11:30 a.m., Saturday, April 17, at the Arlington Hotel in Hot Springs. The President of the Fifty Year Club is Joe Verser, M.D., of Harrisburg.

Physicians eligible for the Fifty Year Club this year are:

John Adametz, North Little Rock
Alfred A. Berger, Helena
Curry B. Bradburn, Jr., Little Rock
A. J. Brizzolara, Little Rock
Layne E. Carson, Little Rock
Edwin V. Dildy, Texarkana, TX
Eldon Fairley, Osceola
Harlan C. Holmes, Little Rock
E. L. Hutchison, Heber Springs
Haynes G. Jackson, Hot Springs
William E. Knight, Fort Smith
Frank G. Kumpuris, Little Rock
Frank T. Padberg, Chicago, IL
T. N. Rodman, Leachville
John A. Rollow, Rogers
Walton R. Warford, North Little Rock
James W. Webb, Jonesboro
Frieda Wilhelm, Dallas, TX
Harmon Lushbaugh, Lowell
Albert E. Martin, Jr., Bella Vista
Robert R. Matthews, Little Rock
James S. Mize, Pocahontas
Bert L. Phillips, North Little Rock
Robert H. Robbins, Mountain Home
Guy U. Robinson, Dumas
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Henry M. Sims, North Little Rock
Robert F. Shannon, Little Rock
John D. Smoot, Pocahontas
C. Yulan Washburn, Ward
Charles H. Weber, Magnolia
Thomas E. Williams, Newport
S. Morris Young, Jonesboro

Memorials

Members of the Arkansas Medical Society and Auxiliary who have died during the past year will be remembered during the opening House of Delegates beginning at 5:00 p.m., Thursday, April 15th, in the Arlington Hotel. Members to be remembered are:

Society Members:

Jeff J. Baggett, Prairie Grove
Augustus J. Baker, Las Cruces, NM
Carl T. Beck, Mountain View
T. Henry Dembinski, Hot Springs
Lawrence E. Drewrey, Camden
Edgar J. Easley, Little Rock
Eugene T. Ellison, Sr., Texarkana, TX
Elizabeth C. Fields, Jackson, TN
Laurence G. Fincher, Sr., El Dorado
Robert E. Glasscock, Pine Bluff
James H. Growdon, Little Rock
Anthony C. Hooper, Ballwin, MO

Auxiliary Members and Spouses:

Mrs. John D. Ashley (Jewel), Newport
Mrs. Kelsy Caplinger (Elizabeth), Little Rock
Mrs. Hugh Edwards (Geneva), Searcy
Mrs. Milton C. John (Amelia), Little Rock
Mrs. Wilbur G. Lawson (Barbara), Fayetteville
Mrs. Howell E. Leming (Lorena), Fayetteville
Mrs. Paul L. Mahoney (Gladys), Little Rock
Mrs. William V. Newman (Leona), Little Rock
Mrs. Howard S. Stern (Eleanor K.), Houston, TX

Specialty Meetings

The Arkansas Medical Society invites any specialty society to meet after lunch on Saturday, April 17. The afternoon is also free to relax, enjoy horse racing at Oaklawn or other activities.

The Mind-Body Connection: Treating Anxiety Disorders

April 17, 1993 — Dallas, TX
April 24, 1993 — Atlanta, GA

- Integrated and Pharmacologic Treatment
- Psychotherapy and Pharmacokinetics
- James Barbee, MD, Sheldon Preskorn, MD, W. Walter Menninger, MD, Katherine Shear, MD

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House of Delegates

The opening session of the House of Delegates of the Arkansas Medical Society will begin at 5:00 p.m. on Thursday, April 15. Speaker of the House John Crenshaw, M.D., will preside, assisted by Vice Speaker Brenda Powell, M.D.

All items of business to be considered by the House must either be printed in the convention issue of *The Journal* or submitted to the headquarters office in writing 20 days prior to the meeting. Any new business proposed during the session of the House of Delegates must have a two-thirds vote of attending delegates for introduction.

Items of business will be referred by the Speaker of the House of Delegates to one of two reference committees. Open hearings on those items of business will be held by the reference committees on Friday, April 16 at 10:00 a.m. All members of the Society are welcome to attend the meetings of the reference committees and to express views on the various reports, resolutions, etc.

The following will be seated at the House of Delegates meeting during the 1993 Annual Session:

Officers

John Crenshaw, Pine Bluff, speaker, (ex-officio)
Brenda Powell, Hot Springs, vice speaker, (ex-officio)
J. Larry Lawson, Paragould, president (ex-officio)
Glen F. Baker, Little Rock, president-elect (ex-officio)
Steve Schoettle, West Memphis, vice president (ex-officio)
Charles H. Rodgers, Little Rock, secretary (ex-officio)
Lloyd Langston, Pine Bluff, treasurer (ex-officio)

Councilors

District 1: Merrill J. Osborne, Blytheville
Dwight Williams, Paragould
District 2: Lloyd Bess, Batesville
Michael Moody, Salem
District 3: Sam McGuire, Forrest City
Hoy B. Speer Jr., Stuttgart
District 4: Anna T. Ridling, Pine Bluff
Paul A. Wallick, Monticello
District 5: Wayne G. Elliott, El Dorado
Robert Nunnally, Camden
District 6: James D. Armstrong, Ashdown
F. E. Joyce, Texarkana
District 7: Ronald J. Bracken, Hot Springs
Thomas H. Hollis, Hot Springs
District 8: David L. Barclay, Little Rock
Joseph M. Beck II, Little Rock
Paul Cornell, Little Rock
Charles Logan, Little Rock
William N. Jones, Little Rock
R. Jerry Mann, Little Rock
Harold Purdy, Little Rock
District 9: Robert H. Langston, Harrison
David L. Rogers, Fayetteville
Janet Titus, Winslow
District 10: Gerald A. Stolz, Russellville
Paul Wills, Fort Smith
Morton C. Wilson, Fort Smith

Past Presidents (ex-officio)

Charles R. Henry Sr., Little Rock
Joe Verser, Harrisburg
C. Randolph Ellis, Malvern
Joseph A. Norton, Little Rock
H. W. Thomas, Dermott
Ross E. Fowler, Harrison
C. Stanley Applegate Jr., Springdale
C. Robert Watson, Little Rock
John P. Wood, Mena
Ben N. Saltzman, Mountain Home
T.E. Townsend, Pine Bluff
Albert S. Koenig Jr., Fort Smith
W. Payton Kolb, Little Rock
George F. Wynne, Warren
A.E. Andrews Jr., Texarkana
Kemal E. Kutait, Fort Smith
Purcell Smith Jr., Little Rock
Morriss M. Henry, Fayetteville
Asa A. Crow, Paragould
Charles F. Wilkins Jr., Russellville
John P. Burge, Lake Village
C.C. Long, Fort Smith (honorary)
Ken Lilly, Fort Smith
W. Ray Jouett, Little Rock
John M. Hestir, DeWitt
James R. Weber, Jacksonville
William N. Jones, Little Rock
George Warren, Smackover

Ex-officio members shall have the power of voting on all subjects except the election of officers.

Delegates for 1993 (as submitted by county)

County	Delegate	Alternate Delegate
Arkansas (1)		
Ashley (1)		
Baxter (2)		
Benton (3)		
Boone (1)		
Bradley (1)	Joe H. Wharton	Kerry Pennington
Carroll (1)	Oliver Wallace	Harold Stensby
Chicot (1)		
Clark (1)	Noland H. Hagood	James L. Lowry
Cleburne (1)	Lee Vaughn	James C. Lambert
Columbia (1)		
Conway (1)		
Craighead/ Poinsett (6)		
Crawford (1)		
Crittenden (1)	G. Edward Bryant	E. Scott Ferguson
Cross (1)		
Dallas (1)		
Desha (1)	Howard R. Harris	Robert Hoagland
Drew (1)		
Faulkner (1)		
Franklin (1)		
Garland (5)		
Grant (1)	Clyde D. Paulk	Jack M. Irvin
Greene/Clay (1)	Roger E. Cagle	William H. Rollins
Hempstead (1)	Lowell O. Harris	Dan Cardwell
Hot Spring (1)		
Howard-Pike (1)	Joe King	Sam Peebles
Independence (2)	William Waldrip	Ron Simpson
	John R. Baker	
Jackson (1)	M. A. Chauvin	
Jefferson (4)		
Johnson (1)	Donald Pennington	Richard McKelvey
Lafayette (1)	Sanford E. Hutson	
Lawrence (1)		
Lee (1)		
Little River (1)	Joe G. Shelton	
Logan (1)	John R. Williams	William R. Daniel
Lonoke (1)	Jerry C. Chapman	Leslie F. Anderson
Miller (3)	John A. Gillean	F. E. Joyce
	Joseph R. Robbins	
	Herbert B. Wren	
Mississippi (1)		
Monroe (1)	N. C. David	Linda Collins
Nevada (1)		
Ouachita (1)	William D. Dedman	Larry Braden
Phillips (1)	P. Vasudevan	Robert D. Miller
Polk (1)		
Pope (2)		
Pulaski (32)	D. B. Allen	James R. Adametz
	Raymond Biondo	John P. Brizzolara
	Amail Chudy	J. Roger Clark
	Bob E. Cogburn	Byron D. Curtner
	Claudia Davis	Claudia Davis
	Phillip Deer, III	Gilbert Dean
	Kurt Dilday	Eric Fraser
	Marlon Doucet	Cynthia Frazier
	Jim English	David L. Gilliam
	Charles Fitzgerald	James Hagler
	A. Tharp Gillespie	A. David Hall
	William E. Golden	Andrew Henry
	Edwin Hankins, III	J. Timothy Hodges
	Fred O. Henker	Jerry C. Holton
	C. Reid Henry	Harold G. Hutson
	Tom Jansen	Gail Jones
	Anthony Johnson	John C. Jones
	Carl L. Johnson	Dean Kumpuris
	David King	Stephen K. Magie
	Marvin Leibovich	Judy McDonald
	Gail McCracken	Walter O'Neal
	Fred G. Nagel	David Newbern
	George A. Norton	Michael Roberson
	J. Mayne Parker	Johnny K. Smelz
	Carl J. Raque	Stephen Williamson
	John F. Redman	Virgil D. Wooten
	Ashley S. Ross	
	Ted Saer	
	Bruce E. Schratz	
	Frank M. Sipes	
	William L. Steele	
	Robert G. Valentine, Jr.	
	Samuel Welch	
	John L. Wilson	
	Paul W. Zelnick	
Randolph (1)		
Saline (1)	Mark Martindale	Marvin Kirk
Sebastian (9)	Randy Ennen	Jimmie G. Atkins
	R. Cole Goodman	Mike Berumen
	David Kocher	David W. Hunton
	John R. Swicegood	John L. Lange
	William Schemel	Steve B. Nelson
	John H. Wikman	Andre Nolewajka
	John D. Wells	Jerry Stewart
	Carl L. Williams	Eric Taft
Sevier (1)		
St. Francis (1)	Samuel A. McGuire	
Tri-County (1)	George W. Jackson	Griffin Arnold
Union (2)		
Van Buren (1)	John A. Hall	Charles G. Pearce
Washington (6)		
White (2)		
Woodruff (1)	James E. Rowe	
Yell (1)	James L. Maupin	Gene Ring
Medical Student (1)	Amanda Ferrell	Steve Osmon
Resident (1)		

Ex-officio members shall have the power of voting on all subjects except the election of officers.

First Meeting, House of Delegates

5:00 p.m., Thursday, April 15
John Crenshaw, M.D., Speaker
Brenda Powell, M.D., Vice Speaker

1. Call to order
2. Presentation of the Colors
3. Welcome to Hot Springs
4. Introduction of guests:
   Mrs. Barbara Tippins, Field Director
   American Medical Association Auxiliary
   Mrs.Mildred Taylor, President-elect
   Southern Medical Association Auxiliary
   Mrs. Sandy Harrison, President
   Arkansas Medical Society Auxiliary, Little Rock
   Mrs. Arleta Power, President-elect
   Arkansas Medical Society Auxiliary, Little Rock
5. Adoption of minutes of the 116th Annual Session as published in the June 1992 issue of *The Journal of the Arkansas Medical Society.*
6. Memorials
7. Presentations
8. Old Business
9. New Business
   All reports, resolutions, and other items of business received by the headquarters office 20 days prior to the meeting shall be included in the agenda. Any items of business received after April 5th, must have two-thirds consent of attending delegates before introduction. All items will be referred to reference committees.
10. Recess until Saturday

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Final Meeting, House of Delegates

10:30 a.m., Saturday, April 17
John Crenshaw, M.D., Speaker
Brenda Powell, M.D., Vice Speaker

1. Call to order
2. Election of officers. Nominations as submitted by the Nominating Committee:

President-elect:
James M. Kolb, Jr., M.D., Russellville
Vice President:
Gary L. Bevill, M.D., El Dorado
Treasurer:
Lloyd G. Langston, M.D., Pine Bluff
Secretary:
Charles H. Rodgers, M.D., Little Rock
Speaker of the House:
John Crenshaw, M.D., Pine Bluff
Vice Speaker of the House:
Brenda Powell, M.D., Hot Springs
Councilors:
District 1:
Don B. Vollman, Jr., M.D., Jonesboro
District 2:
Lloyd G. Bess, M.D., Batesville
District 3:
Hoy B. Speer, Jr., M.D., Stuttgart
District 4:
Anna T. Ridling, M.D., Pine Bluff
District 5:
Wayne G. Elliott, M.D., Camden
District 6:
John A. Gillean, M.D., Texarkana
District 7:
Thomas H. Hollis, M.D., Hot Springs
District 8:
Paul J. Cornell, M.D., Little Rock
William N. Jones, M.D., Little Rock
Charles W. Logan, M.D., Little Rock
Joseph Beck, M.D., Little Rock
J. Mayne Parker, M.D., Little Rock
(new councilor position)
District 9:
David L. Rogers, M.D., Fayetteville
District 10:
Paul I. Wills, M.D., Fort Smith
Delegates to the AMA:
James R. Weber, M.D., Jacksonville
(1/1/94 - 12/31/95)

William N. Jones, M.D., Little Rock
(1/1/93 - 12/31/94 to fill Dr. Asa Crow's unexpired term)

Alternate Delegate to the AMA:
J. Larry Lawson, M.D., Paragould (to fill Dr. Jones' unexpired term ending 12/31/93 and serve term beginning 1/1/94 - 12/31/95)

3. Address by Past President of the Arkansas Medical Society, J. Larry Lawson, M.D.
4. Reports of Reference Committees:
   Committee #1
   Committee #2
5. Supplemental report of the Council:
   Charles W. Logan, M.D., Chairman
   (Report covers meetings of the Council held during the annual session.)
6. New Business:
   Announcement of nominees for the Arkansas State Medical Board and the Arkansas State Board of Health
   Other new business

Meetings of the Council

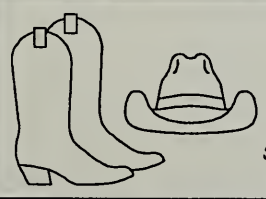
The Council will meet at the following times:

Thursday, April 15	2:30 p.m.
Friday, April 16	7:30 a.m.

A third Council meeting will be called at the discretion of the Chairman if needed.

Reference Committees

Reference Committees are appointed by the Speaker of the House of Delegates to consider the various reports and resolutions. Reports published in this issue of *The Journal,* as well as any reports and resolutions presented at the first meeting of the House on April 15, will be referred by the Speaker to the reference committees. The committees will hold open hearings at 10:00 a.m. on Friday, April 16. After the hearings, the reference committees will hold executive sessions for the purpose of preparing recommendations and reports for the House of Delegates. Reports of the Reference Committees will be acted upon by the House of Delegates at the Saturday session.



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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

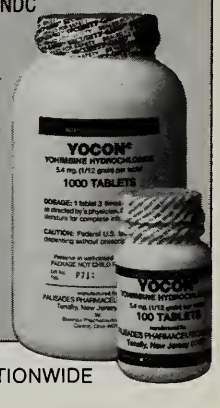
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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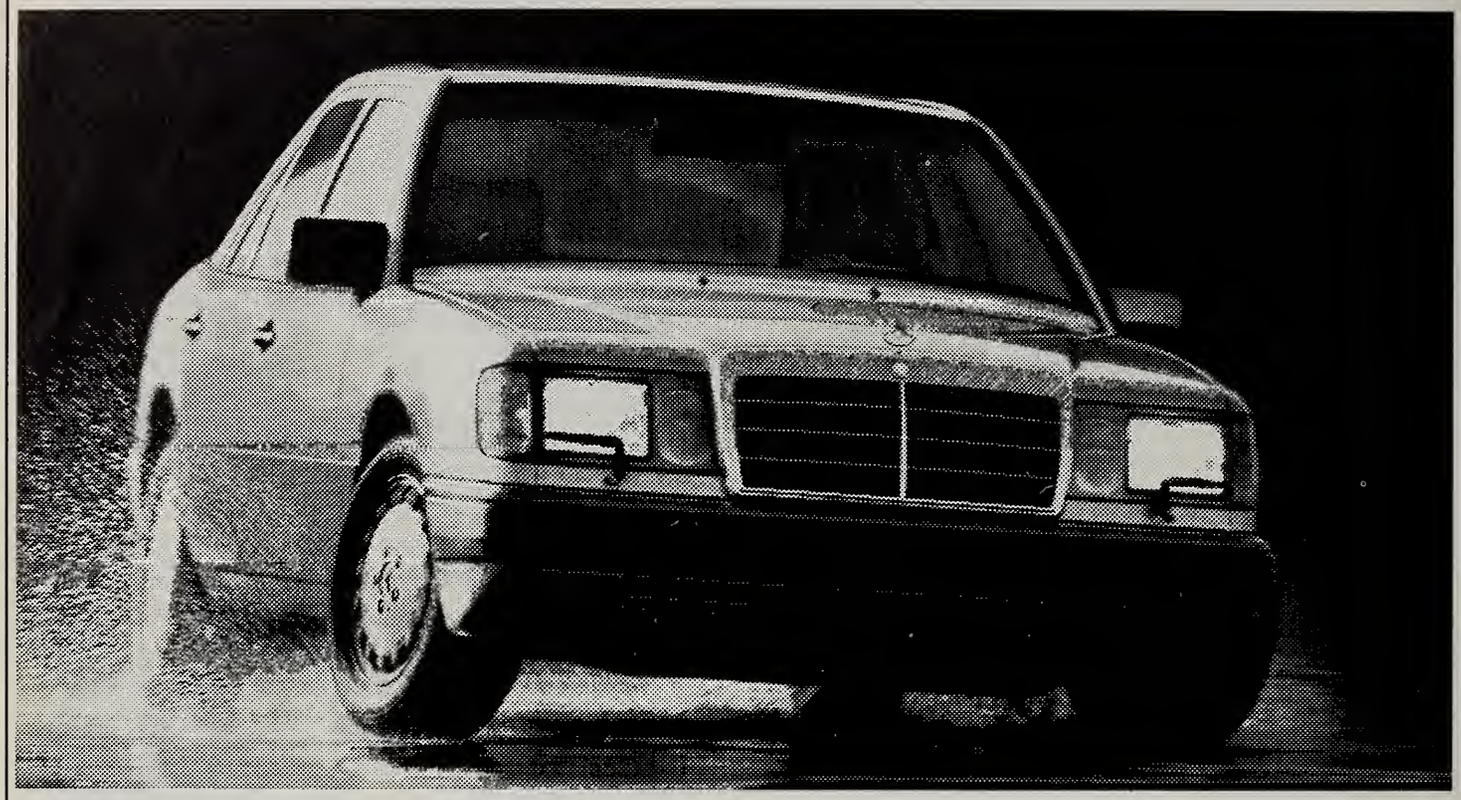

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Business Reports

Nominating Committee
Michael Moody, M.D., Chairman

The Nominating Committee met on Saturday, October 17, 1992, at the Arkansas Medical Society office in Little Rock. Those in attendance were Drs. Michael Moody, Chairman, Richard O. Martin, Samuel McGuire, Wayne Elliott, Herbert Wren, Thomas Hollis, Harold Purdy, and David Rogers. The committee met again by conference call on Wednesday, January 13, 1993. Participating in the conference call were: Drs. Mike Moody, Samuel McGuire, Wayne Elliott, Herbert Wren, Harold Purdy, and William Galloway.

We wish to present to the Society the following nominees:

President-elect: James M. Kolb, Jr., M.D., Russellville
Vice President: Gary L. Bevill, M.D., El Dorado
Treasurer: Lloyd G. Langston, M.D., Pine Bluff
Secretary: Charles H. Rodgers, M.D., Little Rock
Speaker of the House: John Crenshaw, M.D., Pine Bluff
Vice Speaker of the House: Brenda Powell, M.D., Hot Springs
Delegates to the AMA:
James R. Weber, M.D., Jacksonville (1/1/94 - 12/31/95)
William N. Jones, M.D., Little Rock (1/1/93 - 12/31/94 to fill Dr. Asa Crow's unexpired term)
Alternate Delegate to the AMA:
J. Larry Lawson, M.D., Paragould (to fill Dr. Jones' unexpired term ending 12/31/93 and serve term beginning 1/1/94 - 12/31/95)
Councilors:

District 1:	Don B. Vollman, Jr., M.D., Jonesboro
District 2:	Lloyd G. Bess, M.D., Batesville
District 3:	Hoy B. Speer, Jr., M.D., Stuttgart
District 4:	Anna T. Ridling, M.D., Pine Bluff
District 5:	Wayne G. Elliott, M.D., Camden
District 6:	John A. Gillean, M.D., Texarkana
District 7:	Thomas H. Hollis, M.D., Hot Springs
District 8:	Paul J. Cornell, M.D., Little Rock
	William N. Jones, M.D., Little Rock
	Charles W. Logan, M.D., Little Rock
	Joseph Beck, M.D., Little Rock
	J. Mayne Parker, M.D., Little Rock (new councilor position)
District 9:	David L. Rogers, M.D., Fayetteville
District 10:	Paul I. Wills, M.D., Fort Smith

Task Force on AIDS
Joseph M. Beck II, M.D., Chairman

The AMS Task Force on AIDS held five meetings during 1992. The Task Force members have been: Drs. Joseph M. Beck II, Chairman; Jim Acklin, Susan Beland, Barbara J. Bozeman, A. Stuart Fitzhugh, Donald C. Fournier, Harold Hedges, Charles R. Henry, William N. Jones, Linda M. McGhee, E. Clinton Texter Jr. Other members of the Task Force include: Mrs. Arleta Power, AMSA representative, Scott Stanley and Scott Hogan, medical student representatives, Fred Church, D.D.S., Arkansas State Dental Association representative.

The number of AIDS cases continued to rise in both Arkansas and the United States. In the U.S., there have been 242,146 AIDS cases reported to the Centers for Disease Control since 1981 and 238,095 deaths (Third Quarter Edition). Since 1983, there have been 786 AIDS cases reported to the Arkansas Department of Health and 431 deaths (Autumn, 1992 Report). In an effort to address this ever increasing number of cases, the Task Force continued its educational activities to all demographics.

Because of a federal mandate to the state health departments to establish policy of risk prone procedures, etc. or lose federal funds, the Task Force met to discuss the issue. The Task Force drafted a letter to send to the AIDS Advisory Board of the Arkansas Department of Health that said it did not believe it was possible to compile a list and once again reiterated universal precautions. The Task Force felt each incident should be on a case by case basis.

During 1992, the Task Force also drafted a proposal to assist physicians infected with blood borne diseases. An outline of the program was presented to the AMS Executive Committee and the AMS Council. It was approved by both bodies and is now AMS policy. A copy of the policy was forwarded to the Director of the Arkansas Department of Health and the Arkansas State Medical Board.

The program was designed to be voluntary. The Committee for Physicians with Blood borne Diseases would be confidential. However, it the infected physician failed to follow the Committee's recommendation's and might endanger the public or him/herself, the Committee would report this to the Arkansas State Medical Board for follow-up.

On April 11, 1992, over 250 health care professionals attended the Fifth Annual AIDS Seminar in Little Rock at the Excelsior Hotel. Dr. Brady Allen of Dallas, Texas, was the keynote speaker. The program also included a panel of local physicians and Dr. Allen, and it addressed

the issue of HIV management. The Task Force is currently planning the Sixth Annual AIDS Seminar, which will be held in Hot Springs on Saturday, May 22, 1993 at the Ramada Inn.

The medical student program, Fighting AIDS Through Education (F.A.T.E.), continued in 1992. As the school year began, over one-half of the sophomore class signed up for the program. Participants in the program speak to school children on the subject of AIDS and HIV disease.

As in previous years, the monthly AIDS and HIV statistics from the Arkansas Department of Health were reprinted in *The Journal of the Arkansas Medical Society*. The Committee voted to also start reprinting the AIDS/HIV Quarterly Report from the Arkansas Department of Health, which will appear in the January, 1993 issue of *The Journal*. Because of budget cuts, the Department can not maintain their mailing list, and the Task Force felt that many physicians would miss receiving vital information. The following articles were published in *The Journal* in 1992:

"UAMS F.A.T.E. Program Recognized by the AMA" by Scott Stanley

"Knowledge of Chemical Abuse and AIDS Among Gifted Junior High Students in Little Rock" by H. Stefan Bacha, M.D. and Adam S. Bacha

Annual Session Committee
Glen F. Baker, M.D., Chairman

"The Changing World of Medicine" was the theme for the 116th Annual Session of the Arkansas Medical Society meeting held in Little Rock, April 9-11, 1992. Nearly 500 physicians and spouses attended the meetings and other events and toured the exhibit hall. Over 200 exhibitors and sponsors from 73 different companies welcomed those in attendance.

Penny Washington, Reimbursement Specialist for the North Carolina Office of Rural Health and Resource Development, examined the issue of rural health clinics. A panel made up of Drs. John Grasse, Jr., Reginald J. Rutherford, and Joanna Thomas discussed their experiences of practicing in other countries. John C. Goodman, President of the National Center for Policy Analysis, presented "An Agenda for Solving America's Health Care Crisis", at the Shuffield Luncheon.

The third feature session was a panel discussion on the implications of RBRVS, presented by James N. Haug, Director, Socioeconomic Affairs Department of the American College of Surgeons; James R. Weber, M.D., an American Academy of Family Physicians representative to the RBRVS Study for Physician Reimbursement; and Joseph T. Painter, M.D., Chairman of the Board of Trustees of the American Medical Association.

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Thanks to the sponsors, exhibitors, and the participation of Arkansas Medical Society members and guests the entire convention was informative, entertaining, and a big success.

Stop by and visit our '93 exhibitors on Thursday, April 15 and Friday, April 16!

117th Annual Session • Arlington Hotel • Hot Springs

AMS Benefits, Inc.
David W. Wroten, Vice. President, Chief Operating Officer

BACKGROUND

AMS Benefits, Inc. (the Corporation) was established in November of 1991 as a for-profit, wholly-owned subsidiary of the Arkansas Medical Society. The Corporation is managed by a Board of Directors consisting of the following individuals:

J. Larry Lawson, M.D.
Glen Baker, M.D.
George Warren, M.D.
Lloyd Langston, M.D.
Lynn Zeno, Secretary
David Wroten, Vice-President, C.O.O.
Ken LaMastus, President

The Corporation was established primarily as a mechanism to administer the newly created AMS health insurance program. It was necessary to place the administration of this program under a for-profit subsidiary to protect the tax-exempt status of the AMS. The Corporation is also licensed by the State as an insurance agency thereby allowing us to market other insurance products in addition to the health program.

Start-up funding for the Corporation consists of two $50,000 loans from the AMS. These loans were executed through an arms-length transaction approved by the AMS Council. The terms are as follows: Loan #1 - 8% annual interest renewable each year for up to five years; loan #2 also 8% annual interest but due after two years. The first interest payment was made in February of 1993 totalling $4,000. The AMS also receives income from the Corporation to cover the actual cost of providing space, postage, and other office expenses and supplies.

The Corporation currently employs one person, Alanna Scheffer. Ms. Scheffer serves as the Plan Administrator for all AMS insurance programs, and is the medical underwriter for the AMS Health Benefit Plan.

PRODUCTS

Currently, our primary business is the administration and marketing of all AMS insurance programs. Products sold and/or administered by the corporation include health insurance, life, business overhead, group and individual disability. The emphasis of course has been on the AMS Health Benefit Plan (the Plan). The Plan was established in January of 1992 as a partially self-funded group health insurance plan. It is available only to AMS members and their employees. The Plan offers competitive benefits at sometimes substantial savings over current group plans in the market. Over 40 clinics across Arkansas are currently taking advantage of this important program. The Plan is also reinsured by Lloyds of London; a safety feature we are quite proud of.

Another important product is the disability program. Thorough a special arrangement with Provident Life and Accident, AMS members can purchase individual, non-cancellable disability coverage with lifetime premium discounts. In addition to being one of the largest writers of disability products, Provident has distinguished itself from the crowd by being the first company to state, in writing, its policy on HIV infection.

MARKETING

While the Corporation is chiefly responsible for the "administration" of AMS insurance programs, we have elected to go outside for most of the marketing and sales functions. Bean, Hamilton & Associates, an independent insurance firm in Little Rock serves as our Marketing/Sales representative.

The benefit of having an independent agency market our insurance products is that it allows us to offer AMS members a broader range of plans to meet their individual needs. More importantly, however, is the convenience this arrangement provides to the busy medical practice. Through AMS Benefits physicians have a single source from which to purchase a variety of insurance products rather than having to negotiate with several different agents selling different products.

BUSINESS OUTLOOK

The Corporation currently receives income from fees charged to administer the health insurance program and commissions earned from life, disability and other insurance products. The number of clinics covered by the health insurance plan is expected to double during 1993. While this is a somewhat conservative estimate, it should put the Corporation well in the black and in position to begin retiring the AMS loans early next year.

During the year we will be investigating opportunities and products that will meet the needs of AMS student and resident physician members. That would open up an entirely new market for AMS insurance products while developing long-term relationships with future practicing physicians. At the same time, our marketing plans for existing products are being fine-tuned to insure that we are reaching our AMS membership and to insure that their needs are being met.

FINAL WORD - CORPORATE PHILOSOPHY

While the Corporation was created for very specific reasons, our continued existence will be guided by a very simple philosophy. AMS Benefits exists for the sole purpose of improving and enhancing the ability of the Arkansas Medical Society to meet the needs of its members.

Budget Committee
Paul Wallick, M.D., Chairman

The Budget Committee submitted the following budget for 1993. The complete budget, as presented to the Council, is available to members upon request.

Income	*Amount Budgeted*
State Society Dues & MEFFA	$610,000.00
Journal Advertising	89,000.00
Booth Income	36,500.00
Annual Session	38,000.00
AMA Reimbursement	8,000.00
Miscellaneous & Rosters	14,000.00
Interest Income	34,000.00
Specialty Desk	2,400.00
Continuing Medical Education	2,200.00
Rent & Land Lease Income	1,749.00
Allocation of G.A. Department	5,000.00
Educational Programs	12,000.00
Total	**852,849.00**

Expenses	
Salaries	252,982.00
Travel & Convention	55,000.00
President's Account	6,000.00
Taxes	26,000.00
Retirement	29,700.00
Stationery & Printing	14,000.00
Office Supplies & Expenses	20,000.00
Telephone	11,000.00
Rent	79,672.00
Postage	30,000.00
Insurance & Bonds	55,000.00
Auditing	5,000.00
Council & Executive Committee	4,800.00
Journal Expense	66,800.00
Dues & Subscriptions	3,500.00
Gifts & Contributions	2,500.00
Auxiliary	2,200.00
Legal Services (retainer)	27,426.00
Special Committees	1,200.00
Public Relations	3,000.00
Miscellaneous Expenses	5,000.00
Office Equipment & Furniture	20,000.00
Continuing Medical Education	1,000.00
Richmond Early Retirement	5,820.00
Contract Labor	500.00
AMS Resident & Student Section	5,500.00
AIDS Committee	1,500.00
Annual Session 1992	69,000.00
Educational Programs	6,000.00
Physicians Health Committee	10,000.00
MEFFA - Dues	10,000.00
Total	**$830,100.00**

Department of Governmental Affairs

Income	**$204,697.00**
Expenses	**Amount Budgeted**
Salaries	$92,142.00
Retirement	10,700.00
Taxes	8,300.00
Stationery & Printing	6,500.00
Office Supplies, Telephone, Misc. Expenses	6,500.00
Equipment & Furniture	1,000.00
Auto, Travel & Meeting	40,000.00
Legal Retainer	18,300.00
Postage	15,500.00
Insurance & Bonds	8,500.00
Office Allocation To AMS	5,000.00
Audit	1,000.00
Total	**$213,442.00**

Report of the Council
Charles W. Logan, M.D., Chairman

AMS Council

The Council met on February 9, 1992, and the following business was received and transacted:

1. Approved the minutes of the November 24, 1991 Council meeting.

2. Approved the minutes of the November 27, 1991 and January 22, 1992 Executive Committee meetings.

3. Chairman Charles Logan expressed his condolences for Dr. Larry Lawson and his family in the death of his mother.

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4. Mrs. Charles Rodgers, President of the AMS Auxiliary, thanked the Council for their contribution to the Arkansas Health and Education Foundation. The Council approved a request by Mrs. Rodgers to designate the money in the Brooksher Fund for radiology technology students.

   Mrs. Rogers discussed the Adolescent Health Seminar, mentioned the silent auction to benefit AMA-ERF to be held at annual session, and the Doctors' Day page in the March issue Journal of the Arkansas Medical Society.

5. Received an update from Dr. Payton Kolb, Delegate to the AMA, on the activities at the AMA interim meeting December 7-9, in Las Vegas. Received a report from Ms. Katherine Henry, President of the AMS Medical Student Section, on the AMA Medical Student Section meeting. She also thanked the Council for sending her to Las Vegas.

6. Received information from Dr. Logan on how the AMA is composed.

7. Received information from Mike Mitchell, AMS General Counsel, on the scope of practice of nurse practitioners.

8. Recommended that we ask the State Medical Board to investigate the practice of nurse practitioners being able to dispense and implant Norplant. Based upon our legal opinion, this seems to go beyond medical concerns. A copy of the legal opinion will be sent to the State Board of Nursing.

9. Received an overview of the upcoming annual session to be held in Little Rock, April 9-11.

10. Received information on how the Shuffield Award recognizes an individual for their contributions to health care.

11. Received an update on the status of the AMS Building. The mortgage company has written a letter indicating their plans to accelerate the loan and therefore foreclose on the building including the property.

12. The Membership and Budget Reports were presented.

13. Goals of the AMA and AMS to have a smoke-free society by the year 2000 was presented by Mr. Lynn Zeno and Dr. Bill Jones. Dr. Jones explained that a $0.20 tax on cigarettes would raise $50 million for the Medicare provider tax and programs for the elderly.

14. Received information on a fund-raiser being planned for Representative John Lipton in March.

15. Information was given that the Workers' Compensation Commission plans to use the Medicare Fee Schedule. Steps are being taken to get the commission to reconsider and look at another alternative.

16. Received information from Dr. Mike Moody of the changes related to the Medicaid Prior Authorization Program.

17. Dr. George Warren asked for contributions for MED-PAC. He also discussed an OSHA recordable injury situation that had occurred with his practice.

18. Received an update from Mr. David Wroten on the new insurance program and the for-profit subsidiary, AMS Benefits, Inc. Provident Life and Accident Insurance Company will be the new carrier for disability insurance.

19. Approved a $3,500 expenditure to assist in the formation of a coalition to develop an initiated act campaign to increase the tax on tobacco to fund programs for the elderly and provide funding for Medicaid to replace the provider tax which expires June 30, 1993.

20. Voted to retain a consultant who would negotiate the purchase price of the AMS building. His fee would be $5,000 to $7,000 or no more than $1,500 if the negotiations do not go through.

21. Approved a loan in the amount of $50,000 to AMS Benefits, Inc., as start-up money for the new insurance program. The loan is at 8% interest for one year, renewable for five consecutive years.

22. Dr. Charles Logan requested suggestions for several Council committee appointments.

23. Welcomed two new councilors, Dr. Lloyd Bess of Batesville, a Second District Councilor, and Dr. Robert Nunnally of Camden, a Fifth District Councilor.

24. Received information from Dr. Morton Wilson on the activities of the PRO. The position of Medical Director of the PRO is still open. A training session for new physician advisers will be held in Little Rock February 13. Also, the PRO annual meeting will be held Sunday morning, April 12, following the AMS annual session.

A report on the April 9, 10, and 11 Council meetings was printed in the June 1992 issue of the Journal of the Arkansas Medical Society.

The Council met June 28, 1992, and the following items of business were received and transacted:

1. Approved the minutes of the April 9-11, 1992 Council meetings.

2. Approved the minutes of the May 27, 1992 Executive Committee meeting.

3. The Membership and Budget Reports were presented.

4. Mr. Mike Mitchell, AMS General Counsel, discussed the 20% cut in Medicaid and the possibility of a lawsuit to enjoin the Department of Human Services (DHS) from implementing cuts July 1st. Approved a motion to proceed with negotiations and, if necessary, file a lawsuit to reverse the DHS ruling. Approval was granted to the Executive Committee to make the final decision on the lawsuit.

5. Approved a proposal to seek professional management for $400,000 of AMS funds to receive better returns on its investments.

After Dr. Elliott explained the need for additional operating capital for AMS Benefits, Inc., the Council approved a loan to AMS Benefits, Inc., in the amount of $50.000.00 for two years at 8% interest rate.

6. Received information from Dr. Joseph Beck, chairman of the Committee on AIDS, on a statewide health committee for health care workers who are infected with HIV. He recommended a change in the guidelines to state that the committee, if necessary, would report directly to the State Medical Board and the HIV physician could be found in violation of the Medical Practices Act if they were not following the committee's recommendations. Approved a recommendation to leave the Physicians' Health Committee out of this issue.

7. Granted approval to move the AMS Employees' Tax Deferred Program from First Variable Insurance Company to Stephens, Inc., or a similar company.

8. Received an update from Dr. William Jones on the Coalition for a Healthier Arkansas (CHAR) and the proposed Tobacco Tax and Health Act.

Granted approval to the Executive Committee (with the Budget Committee's approval) to authorize additional contributions of $15,000 to $20,000 when CHAR presents their request for the money.

9. Received information that the Workers' Compensation Commission was going with the proposal that the Arkansas Medical Society and the State Chamber of Commerce had recommended.

10. Received information that the AMS House of Delegates Winter Meeting would be held November 22, 1992, in Little Rock.

11. Received information from Dr. Glen Baker, chairman of the Annual Session Committee, that a $10,154.76 profit was made on the 1992 Annual Session.

12. Discussion was led by Dr. Mike Moody on physicians' authority to delegate prescribing authority and the proposed addition to the Arkansas Nurse Practice Act Rules and Regulations for Nurse Practitioners regarding prescriptive authority. Approved the recommendation that some possible compromises be discussed with the Nurses Association and recommended having the attorneys for the State Medical Board and Pharmacy Board write the Nursing Board a letter to say it's felt that if the proposal is adopted they would be exceeding their authority.

13. Received an updated from Dr. Payton Kolb on the recent AMA meeting in Chicago.

14. Received an update from Mrs. Sandy Harrison, President of the AMS Auxiliary, on the auxiliary and the national meeting.

15. Received information from Dr. Charles Rodgers on Med-Pac contributions. Med-PAC has given $28,350 in contributions to 101 candidates.

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16. Received information that UAMS is establishing an endowed professorship to be named for Benjamin N. Saltzman, M.D., and dedicated to rural family medicine practice.

17. Appointed Dr. Brenda Powell as interim vice speaker of the House.

18. After discussion from Dr. John Crenshaw on the PRO the Council voted that the MSRC not extend its purview to peer review but to stick with the original intent which was adjudication of fees for Medicare and Blue Cross Blue Shield.

19. Approved a letter to be sent to Terry Yamauchi, M.D., expressing appreciation for his work at DHS. This letter will also be published in the Journal of the Arkansas Medical Society.

20. Received a report from Dr. James Armstrong, Chairman of the Board of Directors of the Arkansas Foundation for Medical Care, on the activities of the PRO.

21. Received a status report on the AMS Building. The escrow account is deficient of about $25,000 and Berkshire has written Flake and Company to demand the account be made whole.

The Council met on Sunday, November 22, 1992, and the following items of business were received and transacted:

1. Approved the minutes of the June 28, 1992 Council meeting.

2. Approved the minutes of the August 26, 1992 Executive Committee meeting.

3. Approved the minutes of the October 28, 1992 Executive Committee meeting.

4. Welcomed two new members to the Council, Drs. William Jones and Joseph Beck. Dr. Brenda Powell was recognized as interim vice speaker of the House of Delegates.

5. A moment of silent prayer was observed for Dr. Robert Shannon who passed away September 30, 1992.

6. Approved the recommendations of the Ad hoc Committee for a UAMS Scholarship Program with two amendments: 1) add Arkansas residents only; and 2) the Scholarship Advisory Committee report to the House of Delegates at the 1993 spring meeting.

7. Received a report on the status of the Department of Human Services lawsuit. The trial will begin November 30th and last approximately one week with a decision being rendered at a later date.

8. Received a report on the current status of the AMS Building and the projected budget for 1993. The liability of the Arkansas Medical Society for the building was also discussed.

9. The Membership and Budget Reports were presented.

10. Received a report from Dr. William Jones on the activities of CHAR. He explained that the Friday Law Firm had filed a lawsuit representing the big tobacco companies in the Supreme Court against the Secretary of State asking that we be decertified from the ballot. CHAR has voted to fight for the tax during the legislative session in January.

Upon a motion (with one opposition) the Council approved a recommendation to ask the officers of MEFFA to reconsider the use of the Friday Law Firm for legal counsel until such time that the firm no longer represents tobacco companies at the expense and to the detriment of the public's health.

11. Approved the selection of physicians to serve on the Physician Advisory Committee to the state Medicare carrier (Blue Cross Blue Shield). The Council also agreed to receive input from specialty societies when making appointments for future committees. The Physician Advisory Committee will provide a report at the end of one year.

12. Dr. Joe Verser asked the Council to reconsider printing the minutes of the State Medical Board meetings in the Journal of the Arkansas Medical Society. The Council instructed the Editorial Board to review the policy and contact the State Medical Board concerning a resolution of this issue.

13. Sandy Harrison, President of the AMS Auxiliary, thanked the Council for their support of the recent auxiliary project which was a teen program entitled, "Choices Not Chances".

14. Received information from Dr. Joseph Beck, Chairman of the Committee on AIDS, on the policy being formulated by the State Medical Board concerning HIV infected physicians which include some areas

of concern: 1) if an exposure prone procedure is done the patient be informed in writing; and 2) the members of the operating team be informed of the physician's HIV status. He told the Council that the State Medical Board was still working on the policy. Dr. Jouett informed the Council if the policy was approved by the Board there would be a public hearing.

The Council convened into executive session to discuss the 1993 AMS Budget.

AMS Executive Committee

The Executive Committee of the Arkansas Medical Society met January 22, 1992, and the following business was received and transacted:

1. Reviewed a letter from Dr. Wright, president of Tri-County Medical Society, concerning exempt status for Dr. Lewis Allen. The Committee agreed that Dr. Allen does not meet the requirements for dues-exempt status. The Committee agreed with the letter written by AMS staff to Dr. Allen.

2. A letter requesting endorsement of a National Cancer Institute Registry grant was reviewed. The Executive Committee asked that we obtain more information before we endorse the program.

3. The Executive Committee considered recommendations to the Governor for the replacement of Dr. Jim Lytle on the Arkansas State Medical Board. Dr. Lytle has submitted the name of Dr. John Bell of Searcy. A letter is to be written requesting two additional recommendations.

4. Discussed the formation of a coalition to develop an initiated act campaign to increase the tax on tobacco to fund programs for the elderly and provide funding for Medicaid to replace the provider tax when it expires June 30, 1993. The Committee approved the action for $3,500 subject to approval by the Budget Committee.

5. Received a report concerning the AMS Employee Benefit Trust and the development of AMS Benefits, Inc. The Executive Committee recommended making a loan to AMS Benefits, Inc. in the amount of $50,000. It was pointed out that this was discussed in the last Council meeting. The Committee recommended the loan should be approved by the Budget Committee.

6. Received a reported on the status of the AMS Building. Mr. LaMastus suggested the hiring of Mr. James Irwin, a consultant, to determine how much we should offer on the AMS Building. It may be necessary to negotiate the deal with Berkshire Insurance. The Committee approved the hiring of Mr. Irwin. Mr. Irwin's fee would be from $5,000 to $7,000. His fee would be no more than $1,500 if a deal was not completed.

The Executive Committee of the Arkansas Medical Society met on Wednesday, February 26, 1992 and the following business was received and transacted:

1. After discussing the current situation of the building, the Executive Committee recommended to Mr. Irwin that he continue non-binding negotiations with Berkshire and report back to the Executive Committee and the Council.
2. Ken LaMastus reported that up until this date there had been no changes in the workers' compensation fee schedule problem. It appears the Workers' Compensation Commission might consider an alternative plan if one were presented. Drs. Logan and Rodgers both agreed to call Dr. George Mitchell, President of Arkansas Blue Cross Blue Shield, to see if Blue Cross Blue Shield would allow their fee schedule to be used by the Workers' Compensation Commission.

3. Approved a list of members-at-large.

4. Approved out-of-state travel for Ken LaMastus to attend the AAMSE State CEO meeting in Charleston, South Carolina in March.

5. Reviewed a letter from Garland County Medical Society to Dr. Warren concerning comments that were made during its meeting with Medicaid some months previous. Dr. Warren recommended a letter of apology be drafted by Mike Mitchell and Ken LaMastus to be mailed to the Garland County Medical Society.

6. Reviewed a letter from the Northwest Arkansas Radiation Therapy Institute. The Committee suggested that the staff correspond to the institute's suggestion that Dr. White have a meeting with the staff of some of the radiation therapy institutes and the insurers concerning the problem of overdue billing for certain aspects of radiation therapy.

7. Reviewed dues exempt status for Dr. Joseph P. Ward. The Committee suggested that a letter be written Dr. Ward to determine if he was actually retired during 1990. If so, dues exempt status should not be given.

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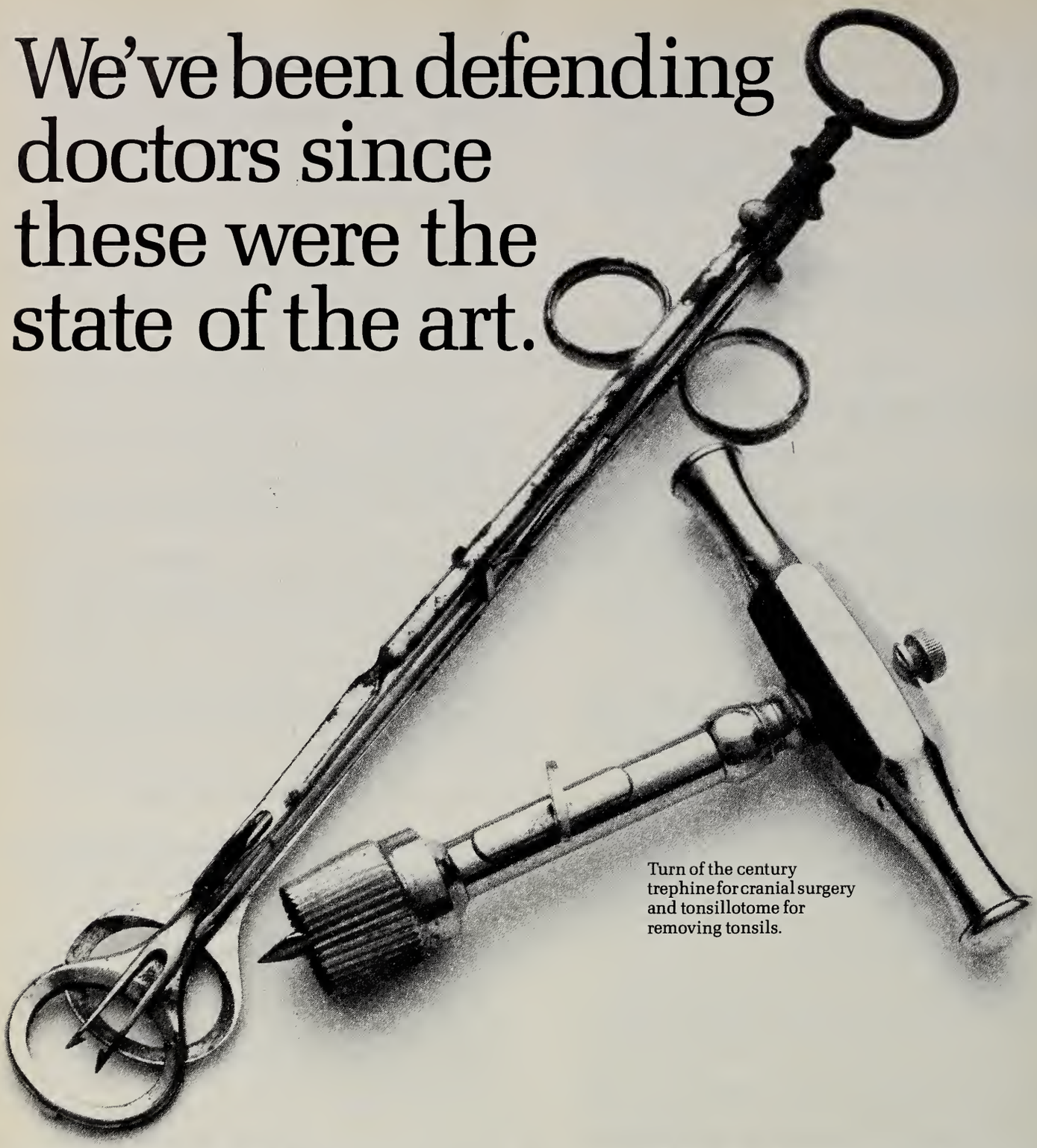

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The Executive Committee of the Arkansas Medical Society met Wednesday, March 25, 1992, and the following business was received and transacted:

1. Discussed meetings with State Chamber of Commerce and Workers' Compensation Commission.

2. Reviewed a letter from Blue Cross Blue Shield. The letter was a notice of cancellation of the Medical Society Group Insurance. A copy of Mr. LaMastus' response was also reviewed.

3. Mr. Jim Irwin suggested a proposed counter-offer to Berkshire Life Insurance Company to take over the AMS Building. The Executive Committee authorized Mr. Irwin to submit an offer.

4. Dr. Rodgers discussed a recent visit to Garland County Medical Society in a matter relating to Medicaid and utilization review by the Executive Committee.

The Executive Committee met on Wednesday, May 27, 1992, and the following business was received and transacted:

1. Mr. Jim Irwin discussed what he has done thus far as our consultant in assisting the Medical Society in obtaining the Arkansas Medical Society Building. Mr. Irwin indicated that the current managers of the building have no escrow money for taxes. Mr. Irwin will continue to work with Berkshire to get them to make concessions to equal the amount needed in an escrow account for taxes. The agreement reached would be faxed to the Executive Committee and a conference call would be held to discuss approval of the agreement.

2. Dr. Joe Beck presented information and asked for the Executive Committee's approval for a method by which HIV positive physicians could work with a subcommittee of the AMS AIDS Committee to enable them to continue their practice. The Executive Committee approved the action. It was mentioned that Dr. Beck and Mr. LaMastus need to discuss this matter with the physician members of the State Board of Health. The Arkansas Department of Health is working on a similar program. The Executive Committee felt Dr. Beck's recommendation was superior.

3. Received an update on AMS Benefits, Inc. and a request for another $50,000 loan subject to approval by the Budget Committee.

4. Funding for the Physicians Health Committee was discussed. It was pointed out that there are some problems trying to function under the current management arrangement. There may be efforts to obtain additional funding to continue the program. Dr. Glen Baker said he would discuss with some of the hospital association people the possibility of some funding from hospitals. Ken LaMastus agreed to talk with Dr. Joe Martindale and try to work out some organizational matters to determine an adequate level of funding.

5. Dr. Charles Rodgers requested to be put on the agenda for the next Council meeting to discuss the new chair in rural health at UAMS to be named after Ben Saltzman.

6. Dr. George Warren mentioned a letter he had received from the Arkansas Department of Health pertaining to the Cancer Committee. Mr. LaMastus indicated he had received a letter also. It was suggested that an AMS staff member attend this meeting to find out more about their efforts.

7. Out-of-state travel was approved for Ken LaMastus and David Wroten to attend the AMA meeting in Chicago. Approval was also given for Ken, David, and Lynn Zeno to attend the AAMSE meeting in Portland, Oregon, July 29 - August 2, 1992.

The Executive Committee met on Wednesday, August 26, 1992, and the following business was received and transacted:

1. Ken LaMastus announced that all arrangements have been made to acquire the AMS Building for the amount of the original mortgage. Mr. Jim Irwin had obtained $25,000 from Berkshire to pay for deferred maintenance on the building. The other terms of the building acquisition were at the rate agreed upon at the Council meeting.

A motion was approved for the Arkansas Medical Society to assume the building on the terms agreed upon at the Council meeting. Part of that motion was to pay Mr. Irwin his fee of $15,000. It was agreed that Dr. Glen Baker would make a report on the final disposition of the building at the next Council meeting.

2. Received a report on the Department of Human Services lawsuit.

3. Approved an additional $20,000 contribution to CHAR. The Budget Committee had recommended the contribution during a conference call. The Executive Committee discussed the money required

by CHAR and suggested that future contributions should be made by individual physicians.

The AMS Executive Committee met on Wednesday, October 28, 1992, and the following business was received and transacted:

1. Dr. Logan discussed the Physician Advisory Committee to Medicare. A suggestion was made that in the future when we get recommendations for MSRC that we also ask about the Physician Advisory Committee and word the letter in such a way as to ask if this person may represent a specialty group in both organizations and possibly others.

2. The Executive Committee recommended Dr. Larry Lawson for the Indigent Care Task Force. The Executive Committee also recommended Simmie Armstrong, Jr., for the Medicaid Advisory Committee.

3. A letter from the Legislative Council requesting the Arkansas Medical Society to set up a "Managed Care" program was discussed. The Executive Committee suggested we notify the Legislative Council of the number of physicians involved in managed care programs in the state. This information will be obtained from a survey being done for the Medical Society. They further recommended we inform the Legislative Council of our Indigent Care Committee. They know the approximate number of physicians who volunteer for that program.

4. A meeting of the specialty society officers was discussed. The Executive Committee gave authorization for the staff to develop such a program. It appears the best date for this may be December 12, 1992.

5. Approved travel for the four members of the management staff of the AMS to attend the AMA meeting in December in Nashville.

6. The AMA Leadership Conference to be held in Atlanta, February 12-15, 1993, was discussed. It was decided that recommendations on who would attend would be discussed at the next Executive Committee meeting.

7. Ken LaMastus gave a brief report on CHAR and the DHS lawsuit.

8. The Executive Committee approved a list of members-at-large to join the AMS.

9. Dr. Lawson discussed the Physicians Health Committee and his continued concern about other funding sources for the committee. Dr. Lawson is to discuss this matter again with his hospital administrator.

The Executive Committee met on November 25, 1992, and the following business was received and transacted:

1. Discussed briefly the UAMS contract with the Arkansas state employees for health benefits. It was suggested that a letter be written to Dr. Harry Ward expressing some concern as to what the Executive Committee is hearing from physicians across the state regarding the relationship between the medical center and physicians across the state that might be created by the contract.

2. Discussed the provider tax and it was a consensus of those present, as well as physicians across the state they have communicated with, that the AMS should be adamantly opposed to a provider tax.

3. Discussed the investment of AMS reserves. The Executive Committee received a report concerning two different groups in utilizing the investment of AMS reserves. The Council took action at its last meeting authorizing the Budget Committee to invest the funds with one of the organizations, Merrill Lynch or Paine Webber.

4. Discussed the AMS Leadership Conference. It was suggested that three physicians be invited to attend the conference. The Executive Committee reviewed some of the latest additions to the Council as potential invitees.

5. Approved a list of physicians as members-at-large.

6. Discussed a fax received from the Arkansas State Medical Board. The State Medical Board does not anticipate capturing data on physicians of Arkansas during the relicensure procedure. It was pointed out that no information would be collected concerning fields of practice as has been done in the past. It was also pointed out that inquiries should be made to the Medical Board as to why and it was felt by the Executive Committee that this is the only source of some valuable information for statistical studies pertaining to physician manpower in the state.

Report of the Executive Vice President
Ken LaMastus, CAE

Arkansas' Governor, Bill Clinton, was elected president on a platform of change. One of the sectors most

often mentioned to change is health care. Many of the states are looking for new and innovative changes in health care delivery. Arkansas is no exception. Most often these changes center around the concept of managed care.

Legislation introduced in the 1993 session of the Arkansas General Assembly apparently will involve considerable emphasis on managed care with workers injured on the job. The Arkansas Medicaid program has asked for a waiver from the HCFA to institute a managed care program using a gate keeper in its program. Arkansas Blue Cross Blue Shield is in the process of instigating a managed care through a PPO type program that will be statewide and will involve negotiated fees. The Blues are also in the process of contracting with other insurance companies to bring them under the umbrella of their contracts with Arkansas physicians to limit fees. Many self insured companies are going to some form of managed care such as PPOs, gate keepers, HMOs, for their insurance benefits for employees.

All of these efforts are being brought about because government, private industry, and the public perceived the cost of health care being out of control and feel that some efforts must be made to make health care more affordable in the United States to be competitive in the global economy. We can expect major changes in the health care delivery. Arkansas physicians will undoubtedly be involved in this whirlwind of change and many will not be happy with these new programs.

Efforts to stop many of these changes is like attempting to stop the tides. The only hope that medicine has nationally as well as in the state is to work within the change and attempt to preserve some resemblance of adequate reimbursement and quality of care. Many of the changes attempted will not be successful nor benefit those providing or receiving services.

Early in 1992 the Arkansas Medical Society became involved in the acquisition of the Arkansas Medical Society building. The partnership that owned the building could not meet the mortgage payments and a lawsuit was filed by the mortgage company. If the suit had been successful the Arkansas Medical Society would have lost the land which it owns as well as the partners loosing their ownership in the building.

Studies by the Society's CPA and a consultant hired to study the building indicated there was probably no way under the then existing ownership the building could remain financially viable even if additional money had been added by the partners or the Medical Society. Neither group could have gotten their money back.

The mortgage company refused to negotiate with the partnership because they had limited liability and no cash available for maintenance or repairs. The Society consultant was able to negotiate a better interest rate. The partners agreed to give up their interest in the building, in effect, loosing their investment.

The Arkansas Medical Society made no down payment on the building. AMS simply acquired the old mortgage at a reduced interest rate and approximately $32,000 was spent for legal and consultant fees. It is anticipated that the building lost $700.00 in 1992.

One concern was that if the Society had not assumed the building it would have lost the $345,000 investment in the land. The consultant anticipates that the building would probably break even over the next few years but the mortgage will be paid down. The loss the Society incurred was the land rent totalling $34,000 per year. This is somewhat off-set by the fact the Society had made a commitment to set aside $30,000 a year toward the future purchase of the building.

Because of increase problems with Medicaid, AMS for the first time, filed a lawsuit against the Department of Human Services because of reductions in reimbursement for physicians. The Society staff and our attorney's opinion, the reduction of fees would lead to problems of accessibility for Medicaid recipients.

Initially an effort was made to obtain a temporary restraining order in federal court to stop the reductions in fees. The Society was partially successful in that the federal judge granted a temporary restraining order for obstetric and pediatric services.

Later a four-day trial was held on the merits of the case. At this time we have not received a final ruling the judge. DHS did withdraw the attempts to reduce fees for obstetric and pediatric services.

Trials such as this can be very expensive and we are hoping the Medical Society in addition to winning all or a portion of the suit will be able to receive legal fees.

In February of 1992 the Society in cooperation with the Mississippi State Medical Association developed a self insured health insurance plan for physicians, their families, and their employees and families. The trust is managed by an AMS developed insurance agency, AMS Benefits, Inc.

Studies today indicate those physicians offices who qualify for the insurance plan are saving significant money compared to other insurance plans. The AMS Benefits, Inc. is operating in the black and anticipates repaying the Medical Society all loans used to start the program. There is concern about what will happen on the national level concerning ERISA exempt benefit plans which now offer some advantages not available to commercial insurance companies.

David Wroten, Assistant Executive Vice President of the Society, is largely responsible for the development of the self insured plan. He was the lead staff person working with our attorneys in the federal lawsuit. During the activities David has become somewhat an expert on physician reimbursement.

During the next few months Medicaid plans to go to an all electronic billing service for Medicaid services. Medicare is pushing very hard to move most of its

claims filing electronically. Many of our members already have some type of computer system to file claims electronically. Those who do not will undoubtedly need to work with some kind of system in the near future. As more and better software becomes available physicians will probably find it is going to be extremely beneficial to keep medical records on a computer system.

A resolution was passed during the April meeting of the Arkansas Medical Society requiring that the AMS work with county medical societies to help develop a scholarship program for medical students attending UAMS. A group of physicians worked to establish a basic outline of how the program should work and suggested appointing a permanent committee to refine and implement the program.

The society staff and many of its members have been extremely busy throughout this past year with the federal lawsuit on Medicaid; developing a AMS benefits health insurance plan; and a special legislative session called by Governor Tucker that would have placed a 1% gross tax on medical services to support DHS. That issue was defeated. We all should be thankful for the efforts that many physicians put forth to help the physicians of this state.

By our best estimates the recent work in the lawsuit, work on the workers' comp program and defeat of the gross receipts tax; the AMS saved Arkansas physicians an estimated average of $10,000 each. That is, 25 times the AMS annual dues.

Governmental Affairs Council
Charles Rodgers, M.D., Chairman

The activities of the Department of Governmental Affairs have encompassed much more than the traditional "60 days every two years" at the State Capitol. Over the past year we have been actively involved in negotiating a worker's compensation fee schedule; filing and conducting a federal lawsuit against the Department of Human Services; and successfully defeating a proposed 1% tax on the gross receipts of medical providers during a December 1992 special legislative session. In addition, we continue to monitor activities on the national level as the federal government struggles with the "health care crisis".

A complete and detailed report of our activities during the 79th General Assembly will be made available at the conclusion of the current legislative session.

Arkansas Health Care Access Foundation, Inc.
Gil Buchanan, M.D., Chairman

As the United States tries desperately to solve the severe problems of its citizen's access to affordable needed health care, Arkansas physicians, dentists, pharmacists, hospitals and home health agencies have continued their voluntary effort to serve fellow Arkansans in need, through the (AHCAF) Arkansas Health Care Access Foundation, Inc. AHCAF continues as a collaboration between the Arkansas Medical Society, the volunteer health professionals, and the Department of Human Services, to make available the widest range of volunteer health services and the most diverse of volunteer medical providers. The program targets Arkansans with incomes below the federal poverty level, who do not have private health insurance and do not qualify for Medicaid or Medicare Part B.

Since the Foundation's inception in 1989, 863 physicians, 63 dentists, 335 pharmacies, 89 hospitals, 41 home health agencies, and 97 Arkansas Department of Health offices have offered voluntary services. 22,222 individuals have been certified as eligible for the program, with 5,221 having received donated medical care. Since the system was designed to have minimal paper work, donated care such as return visits to the referred physician, specialty referrals, and hospital admissions are under reported. Random checking by the Foundation staff has revealed that almost one-half of the initial office visits resulted in additional visits and services by the volunteers.

The most significant change in the service in 1992, was the voluntary participation of three major drug companies, which agreed to donate their specific medications for use. Before this new option was made available, the participating pharmacists were able to offer prescribed medications to the patient, at cost. With the participation of Pfizer, Johnson and Johnson, and SmithKline Beecham, drugs manufactured by these companies are provided free to eligible patients.

Eligibility guidelines are established by the Foundation Board, as those Arkansas residents with incomes below the federal poverty level (ranging from $467.50 per month for a single person household to $1,559.17 for a family of six), and not having health insurance (including Medicaid or Medicare Part B). Eligibility is determined through a simple application process at the local county Human Services offices. The enrollees are listed on the statewide computer system in the Foundation office in Little Rock and are informed to request needed, non-emergency health service by calling the office on an 800 number. Referrals are then made rotational to the most convenient and appropriate medical professional.

Support from all sectors of the health care community is one of the keys to making this a successful program. To continue the progression of services offered by the Foundation, the participation of a large number of health professionals is needed, with as much variability in location and specialty as possible. Since the beginning of the program in 1989, some physicians, by nature of their specialty, have received few or no

referrals through the Foundation, where others have received over 40 referrals. Naturally, the most widely utilized specialties are family practice, internal medicine, gynecology, and pediatrics.

The Arkansas Health Care Access Foundation offers a sincere thank you to all our volunteers for their efforts over the last three years and welcome your continued support in this endeavor. Additional physicians are invited to participate and may call 1-800-950-8233 to receive more information on joining this worthwhile Arkansas effort. You are making a difference!

Medical Education Foundation for Arkansas (MEFFA)
W. Martin Eisele, M.D., President

The members of the Board of Directors of the Medical Education Foundation for Arkansas are W. Martin Eisele, M.D., President, Amail Chudy, M.D., Vice President, Ray Jouett, M.D., and Gerald Stolz, M.D. Ex-officio members are the Arkansas Medical Society president, president-elect, and immediate past president, and the Dean at UAMS.

The foundation is supported by $5.00 from each full dues paying member of the Arkansas Medical Society; those paying partial dues make a proportionate contribution. The primary purpose of MEFFA is to provide support and benefit to medical students at UAMS.

During the last year, MEFFA provided approximately $6,000 to purchase equipment for teaching purposes at UAMS and provided a $5,000 grant to the History of Medicine Associates at UAMS. Funds also provided approximately ten out-of-state guest lecturers for the medical school.

Although the year-end 1992 audit has not been completed we anticipate that MEFFA income has exceeded expenditures. We plan this each year and anticipate that some time in the future MEFFA will be considered a major foundation for medical education.

An independent CPA firm audits MEFFA each year and copies are provided to the Council of the Arkansas Medical Society.

The MEFFA Board encourages physicians and their families to make tax deductible contributions.

Arkansas Medical Society Medical Student Section (AMS-MSS)
Katherine E. Henry, President

The Arkansas Medical Society Medical Student Section began the semester with the annual freshman student and faculty mixer. It was held at the Camelot and was a great time for all with students meeting faculty, good food, and entertainment.

In September, Dr. Chris Hackler presented a very informative program on Living Wills and the power of attorney. He dealt with how the laws very from state to state and held a productive discussion on Living Wills in Arkansas.

In December, Dr. Lannie Mays also presented an educational program on family violence, recognition of behavioral patterns, and methods of responding.

The annual interim meeting of the AMA-MSS was held in Nashville, Tennessee this year. Elise Fortin, Vice President, attended the meeting and reported that the main issue dealt with was to propose different ideas of how to promote primary care.

Officers for 1993 are Debbie Hays, President; Michael Penney, Vice President; Amy Wagoner McLaurin, Secretary/Treasurer; Amanda Ferrell, Delegate; and Steve Osmon, Alternate Delegate.

Ouachita County Medical Society
Robert H. Nunnally, M.D., President

Officers of the Ouachita County Medical Society for the year 1992 are Drs. Robert H. Nunnally, President; Bal Shrestha, Vice President; Jerry R. Kendall, Secretary/Treasurer; Cal R. Sanders, Program Chairman; William D. Dedman, Delegate to the Arkansas Medical Society; and Wayne Elliott and Robert H. Nunnally, Fifth District Councilors.

The following meetings were held:

January 15, Fifth Councilor District meeting in El Dorado, David Busby, M.D., Speaker

February 18, program on Pro System, Tom Brewer, M.D., Speaker

March 10, regular business meeting

April 14, program on substance abuse, Bill Lawson, M.D., speaker

June 9, program on rheumatology, Thomas Presley, M.D. of Shreveport, Louisiana, speaker

August 11, Jim Adamson, M.D. of Arkansas Blue Cross Blue Shield, speaker

September 9, program on nephrology, J. Lewis Bruhton, M.D., speaker

October 13, Ken LaMastus and Lynn Zeno of the Arkansas Medical Society, speakers

December 21 meeting with the medical staff of the Ouachita County Hospital and the Board of Governors and a general business meeting

Officers elected at the December meeting for 1993 are: Drs. Cal Sanders, President; Bal Shrestha, Vice President; Robert H. Nunnally, Secretary; and William D. Dedman, M.D., Delegate to the Arkansas Medical Society.

The Ouachita County Medical Society in collaboration with the Ouachita County Pharmaceutical Association and the hospital employees were able to favorably impact a state senate race and a state representative race.

The Ouachita County Medical Society Newsletter was published at a rate of 500 copies per week until August 10, 1992. At that time the name was changed to Nunnally's Notes on Ouachita County News. Approximately 200 copies per week were mailed, the remainder are distributed locally.

Pension Plan Trustees
James Pappas, M.D., Chairman

The members of the Pension Plan Trustees are Drs. William Rutledge, James Pappas, Robert Langston, and Lloyd Langston, Treasurer of the Arkansas Medical Society.

The trustees have received quarterly reports on the pension plan earnings. A total of the four quarters indicate that the plan earned approximately 9.74% in 1992.

There have been no changes in the pension plan since last year's report. The trustees have not had a formal meeting, however, they have received reports from Worthen Trust Company. There has been no changes in investment strategy.

The plan is a defined contribution plan, this means if the Medical Society makes its monthly contribution to the pension plan there is no way it can become in arrears from underfunding.

At retirement any employee is due the amount allocated in his name. This is different from a defined benefit plan in which contributions must be made to arrive at some fixed level at retirement.

Physician Advisory Committee
Howell Hill, M.D., Chairman

Late in 1992, all Medicare Intermediaries were required to develop a policy advisory committee for Medicare. At Blue Cross Blue Shield it is referred to as the Carrier Advisory Committee.

Dr. Charles Logan, Chairman of the Council, worked with Dr. James Adamson, Medical Director of Blue Cross Blue Shield, to develop the initial committee. It is composed of one representative from virtually all fields of medicine and some other independent practitioners such as an optometrist and chiropractor.

The plans are for this committee to meet quarterly on the same day that the Medical Services Review Committee meets which is normally the fourth Wednesday of the month.

Dr. Charles Logan, in the initial appointments, recommended current members of the Medical Services Review Committee because they are in town and available the same day as the Physicians Advisory Committee meetings.

Letters have been written to each of the specialty groups giving them the opportunity to make an appointment to this advisory committee should the specialty group have appointees they would suggest other than the MSRC members.

I have been elected by the committee to co-chair along with Dr. Adamson at Blue Cross Blue Shield. The members of the committee are listed below. I strongly recommend that if you have concerns over policies of Medicare that you contact the members of this advisory committee to have your concerns heard.

Members of the Committee are:

A	Martin Fiser, Little Rock
AN	Howell Hill, Benton
CD	Anthony Bennett, Little Rock
CDS	William Fiser, Little Rock
CDS	John B. Weiss, Springdale
D	Scott Dinehart, Little Rock
DC	Richard Riley, Little Rock
DO	Kenneth Heiles, Star City
DPM	Richard Bronfman, Little Rock
EM	William McDonald, Little Rock
FP	Dennis Davidson, Batesville
GE	John Baber, Little Rock
GS	Ray Stahl, Mountain Home
HEM	Tony A. Flippin, Fort Smith
IM	John Crenshaw, Pine Bluff
N	Jan Sullivan, Little Rock
NEP	James Wellons, Little Rock
NS	David Reding, Little Rock
OBG	Aubry Talley, El Dorado
ONC	Joseph Beck, Little Rock
OPH	Stephen Magie, Little Rock
OPT	Ralph Wilson, Brinkley
ORS	Marion Hazzard, Paragould
OS	Robert Anderson, Little Rock
OTO	Dwayne L. Ruggles, North Little Rock
P	Max Baker, Fort Smith
PD	Anthony Johnson, Little Rock
PM	Barry Baskin, Little Rock
PS	Luther Walley, Hot Springs
PUD	Gail A. McCracken, Little Rock
PTH	John Slaven, Little Rock
R	John W. Joyce, Little Rock
RHU	Thomas Kovaleski, Little Rock
TR	Cynthia Ross, Little Rock
U	Robert Bell, Russellville

ADM	Morton Wilson, Fort Smith
ADM	James Adamson, Little Rock

AMS Representative/President & Chairman of the Council

GS	J. Larry Lawson, Paragould
U	Charles Logan, Little Rock

National Medical Association Representative

IM	Gary Nunn, Little Rock

Other Representatives

V.J. Bowen, Senior Citizens Outreach Services
Phyllis Brown, AR Medical Review Group
Roger Busfield, AR Hospital Association

Physicians' Health Committee
Joe L. Martindale, M.D., Chairman

The Physician's Health Committee has been involved with twenty-three physicians in 1992. The work load is steadily increasing and funding is not improving. In order for us to grow and better monitor the impaired physician, we need funding. We should be able to make it through 1993 but our future is definitely uncertain after that.

Income	*$45,000.00*
Expenses	
Contract Medical Director	$35,000.00
Computer Software	0.00
Office Equipment	0.00
Office Supplies & Postage	1,000.00
Telephone & Answering Service	1,200.00
Travel - Medical Director	4,000.00
Miscellaneous Expenses	550.00
Total	**$41,750.00**

Committee on Position Papers
James M. Kolb, Jr., M.D.

No new position papers have been written by the committee this year. Crisis after crisis have besieged the Medical Society which have necessitated a maximum effort of the staff and some members of this committee. For example, Workers' Compensation Commission reimbursement; Medicaid fee reduction which led to the Society having filed a law suit; the "sick tax" which Governor Tucker proposed to finance Medicaid; the Medical Society building financial crisis; and the institution of the Arkansas Medical Society insurance plan.

We, the Committee, ask for input from the Arkansas Medical Society officers and membership for subjects that need to be addressed for informational purposes and as positions of the Arkansas Medical Society.

I want to thank the Arkansas Medical Society members serving on this committee.

Pulaski County Medical Society
Fred Reddoch, Executive Director

The Pulaski County Medical Society, under the leadership of President Jerry Mann, M.D., had a good year in 1992. Highlights of the year included:

Joining and actively supporting the Coalition for a Healthier Arkansas.

Financial support of Med-Camps of Arkansas.

Presentation of a scholarship to a medical student at UAMS.

Presentation of the 1992 Arkansas Medical Society Shuffield Award to Mr. Paul Harris, Executive Director of the Pulaski County Medical Society.

Administrative support to the Senior Physicians of Arkansas.

Membership growth leading to the an additional councilor for the Eighth Councilor District.

Continued management of the Pulaski County Medical Exchange.

A membership meeting dedicated to legislative concerns.

Pulaski County Medical Society looks forward to another good year under the new president, D. B. Allen, M.D. Other officers elected were Joseph M. Beck, M.D., President-elect, and Bruce E. Schratz, Secretary.

Ad hoc Committee for a UAMS Scholarship Program
Bob Gosser, M.D., Chairman

The following are the minutes from the Scholarship Committee meeting November 7, 1992:

At the annual meeting in April of 1992 this committee was charged with the responsibility of making recommendations as required by a resolution from the Washington County Medical Society. The resolution urged each county medical society and the Arkansas Medical Society to unite in a coordinated effort to establish a scholarship program to aid Arkansas students attending UAMS and report back to the Council

before the winter meeting of 1992. The committee was established to develop guidelines for the support and administration of a scholarship program.

During its deliberations the committee heard a report that the median debt of medical students is $55,859; 84.5% of the medical students at UAMS have some indebtedness. The amount of indebtedness nationwide is increasing at a rate of 10% a year.

Nationwide only 14.9% of residents are entering the primary care fields of medicine. It is believed that there is some relationship that exists between the amount of indebtedness incurred by the medical students and their selection for their residency. Some have indicated that those with higher debt tend to enter residencies perceived to be in the more financially lucrative fields of medicine.

This committee makes the following recommendations:

1. A scholarship program be developed and, for administrative purposes, be placed under the Medical Education Foundation for Arkansas (MEFFA) since MEFFA is already organized as a tax exempt foundation. This should be done with the full consent and blessings of the MEFFA Board.

2. Contributions made to MEFFA would be tax deductible.

3. The scholarship fund would be developed and used for students (Arkansas residents only) with financial need.

4. A Scholarship Advisory Committee be appointed to recommend awarding of scholarships or no-interest loans to UAMS students.

5. The efforts of this program should be to work with and through the county medical societies.

6. Recognition be given to counties that participate and that those participating counties be consulted concerning loaning or awarding of any funds.

7. Depending upon the success of the program some consideration should be given for an endowment and the aforementioned committee to be appointed be charged with the responsibilities of developing guidelines and ideas to raise funds.

8. The Arkansas Medical Society through the Budget Committee consider contributions to this program on an annual basis.

A new committee to work with the scholarship program will be appointed and is expected to report to the House of Delegates at the meeting in April.

Arkansas State Medical Board
Peggy Pryor Cryer, Executive Secretary

The members and officers of the Arkansas State Medical Board are W. Ray Jouett, M.D., Chairman; Warren M. Douglas, M.D., Vice Chairman; Alonzo D. Williams, M.D., Secretary; Mr. John Currie, Sr., Treasurer; John E. Bell, M.D., Steven F. Collier, M.D., Asa A. Crow, M.D., David C. Jacks, M.D., Mr. Dewey Lantrip; Linda A. McGhee, M.D., Rhys A. Williams, M.D., George F. Wynne, M.D., and James Zini, D.O.

A summary of the board proceedings for 1991 is as follows: 141 reviews of individual complaints; 19 show cause orders; 1 surrender of license; 1 surrender of DEA; 2 suspensions of license; 2 licenses placed on probation; and 9 cases reviewed by AFMC.

In September 1991 the Board voted to eliminate the abuse of temporary permits and the minimum amount of credentialling that had been required. During 1992, this figure dropped from 157 to 12 permits issued each meeting. The application for medical licensure was redesigned as well as the system by which verifications are obtained. Original documentation and verification of schools, all post graduate work, including hospital and other employment, is now required.

The content of the "pink" card which has been used for many years for annual registration and updating changes that occurred during the past year was changed. However, the card remained "pink" for easy identification. The return pocket card was redesigned with instruction for physicians to make copies, have them notarized and forwarded to any facility requiring yearly verification of registration. Any additional certificate was also designed to be retained in their office.

The licenses of physicians who have incorporated are on file with the board were either updated or dissolved due to closure.

The directory, which lists the names and addresses of medical doctors and doctors of osteopathy and other health care professionals, was reformatted to allow for easier usage. The Arkansas Medical Practices Act, as well as Rules and Regulations passed by the board, were incorporated into the new directory for easy reference accessibility.

Physicians and other health care professions licensed for the first time in 1992 are: medical doctors and doctors of osteopathy - 524; participated in the FLEX exam - 126; registered occupational therapists - 95; occupational therapist assistants - 28; physician trained assistants - 25; and respiratory care therapists - 18.

Financial Report - June 30, 1992

Current assets	
Cash	$711,755
Certificates of deposit	450,058
Salary refund receivable	4,352
Accrued interest receivable	3,452
Total current assets	**$1,169,617**
Fixed assets - at cost	
Furniture, fixtures, and equipment	$69,703
Less accumulated depreciation	(28,898)
Net fixed assets	**$40,804**
Total assets	**$1,210,422**

Liabilities and Fund Balances

Current liabilities	
Accounts payable	$49,322
Deferred income	42,620
Accrued payroll taxes	205
Accrued wages	2,715
Accrued unused vacation pay	4,576
Total current liabilities	**$99,438**
Fund Balances	$1,110,948
Total Liabilities and Fund Balances	**$1,210,422**

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Report of the Arkansas Department of Health to the Arkansas Medical Society by M. Joycelyn Elders, M.D., Director

It is my pleasure to provide the Society with a report on the activities of the Department of Health. Upon my confirmation by the United States Senate, I will resign my position as Director of the Health Department to become Surgeon General of the United States and Assistant to the Secretary of the Department of Health and Human Services. Please be assured that I will continue to represent Arkansas' health care interests as well as the nation's in my new position.

I have enjoyed my service with the Arkansas Department of Health since 1987. During this time, Health Department services have achieved phenomenal growth, especially in program areas that serve special populations. This is due, in no small part, to the enthusiasm, dedication and professionalism of the Health Department staff. They are to be commended for all their hard work in implementing my goals for public health in this state.

However, the Health Department's initiatives would not have been as successful without the ongoing support of members of Arkansas' medical community. I want to express my appreciation to you for your assistance. The following highlights the accomplishments of the Department of Health during my tenure. I know the Department will be able to continue the partnership established with the medical society as all of us work together to address the public health needs of our state.

Personal Health Services

* Advocated for the use of the contraceptive device Norplant as an optimum contraceptive method. Arkansas has the high insertion rate in the United States for Norplant.

* Developed and implemented the Arkansas Campaign for Healthier Babies, to increase the number of pregnant women who received early and regular prenatal care. This campaign is a joint effort with the Arkansas Department of Human Services, Arkansas Advocates for Children and Families, March of Dimes (Arkansas Chapter), KATV (ABC), and several hospital and media sponsors.

* Improved prenatal services offered by the health department through upgraded standards of care, increased clinic hours, revised health education classes, high risk pregnancy management services, and a toll-free information line for women's health facts and referrals.

* Implemented an award winning media campaign, "Teenage Pregnancy: Arkansas' Timebomb", developed jointly with KARK-TV (NBC).

* Increased the state's awareness of the need for comprehensive health education in our schools.

* Supported state funding for early childhood education and college scholarships.

* Increased the average monthly WIC caseload 100% between 1987 and 1992. In 1992, Arkansas' WIC caseload exceeded federal standards by 11%.

* Promoted age-appropriate immunizations for children by age two through a special campaign with assistance from state and national leaders, including Arkansas' First Lady Hillary Clinton, Betty Bumpers (wife of Senator Dale Bumpers), and the nation's former First Lady Rosalyn Carter.

* Expanded the statewide computer network to include the assessment of immunization status for WIC patients.

* Established school health centers in 1988 with 1 site and expanded to 26 in 1992. An additional 66 schools provide selected health services.

* Implemented the Arkansas SAFE KIDS Campaign statewide. This program develops interventions to prevent injuries, the number one killer of children.

* Offered HIV testing and counseling services in all Arkansas counties.

* Established a Minority AIDS Education task force in order to target members of the minority community.

* Obtained additional funds for community-based organizations to provide intensive outreach and AIDS/STD education to adolescents.

* Established a full range of in-home services for frail to terminally ill patients, including intermittent to continuous care. The Department now offers 24 hour, 7 day availability.

* Increased early and periodic screenings for Medicaid-eligible children by 980%.

* Initiated newborn screening for sickle cell disease.

Table 1
Personal Health Services
Selected Statistics

Service	Year FY 1988	FY 1992
Family Planning		
Patients	47,995	64,724
Visits	100,876	138,286
Maternity		
Patients	11,195	14,695
Visits	47,615	60,078
Cancer		
Cervical Screenings	40,291	52,873
Mammograms	0*	300
WIC Clients		
Served	88,036	121,048
Child Health		
Visits	70,067	85,093
Early Periodic Screening Diagnosis and Treatment (EPSDT)		
Screenings	4,186	45,252
Blood Lead		
Screenings	1,273	12,260
Hearing		
Screenings	178,505	221,553
Vision		
Screenings	191,081	249,253
Immunizations (doses)		
Polio	105,000	113,388
Diphtheria, Tetanus, Pertussis (DTP)	115,000	136,417
Measles, Mumps Rubella (MMR)	30,000	45,909
Haemophilus Influenzae Type b (HIB)	0**	102,829
AIDS		
Testing and Counseling	7,035	41,644
In Home Services		
Patient admissions	8,335	17,396
Recovering Patient visits	150,687	386,146
Frail Patient hours	426,400	1,238,240
Chronic Patient visits	33,873	27,351
Hospice patient days	711	6,730

* *Mammograms were offered beginning January 1, 1991*
** *Haemophilus Influenzae Type b (HIB) immunization program began July 1, 1989*

Environmental Health Services

* Supported Act 41 of 1992, which authorizes the Department of Health to regulate the segregation, packaging, storage, transportation, treatment and disposal of commercial medical waste.

* Initiated in-depth investigations of injuries involving products, recall inspections to assure that sub-standard products are not available to consumers, and undercover investigations of all terrain vehicle (ATV) dealerships.

* Worked with Arkansas' milk industry to assure that the milk supply is tested for drug residues and other substances such as aflatoxin.

* Adopted a Food and Drug Administration-standardized system of inspecting food service establishments and initiated an inspection method involving hazard analysis and critical control points.

* Implemented Act 277 of 1991 requiring licensure and regulation of individuals who perform heating, air conditioning, ventilation and refrigeration work in order to reduce illnesses caused by poor indoor air quality.

* Provided assurances that Arkansas' water systems comply with the federal Safe Drinking Water Amendments (SDWA). These amendments require testing for a greater number of compounds in water that is available to the public as well as implementation of plans for correcting conditions that violate SDWA standards. Public water supply regulations were also revised to include cross connection control and emergency response provisions.

* Provided information, laboratory testing, and technical assistance to assure that children are not exposed to lead in the schools' drinking water.

* Expanded use of alternate and experimental on-site sewage disposal systems in areas where standard septic tank systems are unsuitable.

* Developed playground safety standards consistent with those of the federal Consumer Product Safety Commission.

* Provided assurances that water wells are properly designed and constructed to minimize the possibility of waterborne diseases.

* Complied with federal laws regarding development of a regional low-level radioactive waste disposal site in Nebraska.

Arkansas' Director of Radiation Control chairs the Central Low-Level Radioactive Waste Compact Commission which includes 5 states.

* Complied with the federal Clinical Laboratory Improvement Amendments (CLIA) in the central Public Health Laboratory facility and initiated compliance efforts for Local Health Unit laboratory activities.

* Initiated comprehensive certification and quality assurance programs for mammography facilities. Arkansas is one of less than 10 states to implement this.

Table 2
Environmental Health Services
Selected Statistics

Service	*Year* FY 1988	FY 1992
Food Service Establishment Inspections	28,736	31,353
Septic Tank Inspections	6,139	7,531
Radiological Equipment Inspections	212	464
Laboratory Samples Analyzed	358,753	456,254
Environmental Complaints Investigated	5,263	6,865
Waste and Wastewater Plans Reviewed	1,451	1,578

Health Care Access

* Worked with the Arkansas Legislature to initiate and pass the following legislation to increase access to health care providers by people located in rural and underserved areas:

* Act 620 of 1989 authorizes the Department of Health to administer a matching (50-50) revolving fund for necessary and appropriate medical services in rural areas. During FY 1992, 21 applications were funded for a total of $225,000.

* Act 537 of 1989 authorizes the Health Department to certify private agents to review health insurance claims in the State of Arkansas. Ninety six (96) agencies have been certified through FY 1992.

* Act 360 of 1991 authorizes an incentive payment of up to five years for physicians who practice in a community with a population of less than 8,000 residents. Currently 9 physicians are being paid by this program.

* Constructed 47 new and renovated 17 other local health units since 1987.

* Implemented one-stop shopping for local health unit patients which has increased patient satisfaction and improved patient care standards.

* Established the Office of Minority Health to work with the Minority Health Commission created by Act 912 of the Arkansas General Assembly.

The Arkansas Department of Health has the firm foundation needed to continue to provide high quality public health services to the citizens of Arkansas. Services of the Health Department will continue to grow as the nation recognizes the value of and invests in preventive health care.

As Surgeon General, I will continue to work to insure that issues related to health care access remain a high priority with the nation's decision makers. Thank you for making my job at the Arkansas Department of Health such an enjoyable one. I know I can count on your support as I leave for my new adventure. ■

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Ted Honghiran
* James M. Kolb, Jr.
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Stanley D. Teeter
W. Robert Thurlby
* Charles F. Wilkins

Pulaski

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* Morton Wilson

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Arkansas HIV/AIDS Report 1983-1993

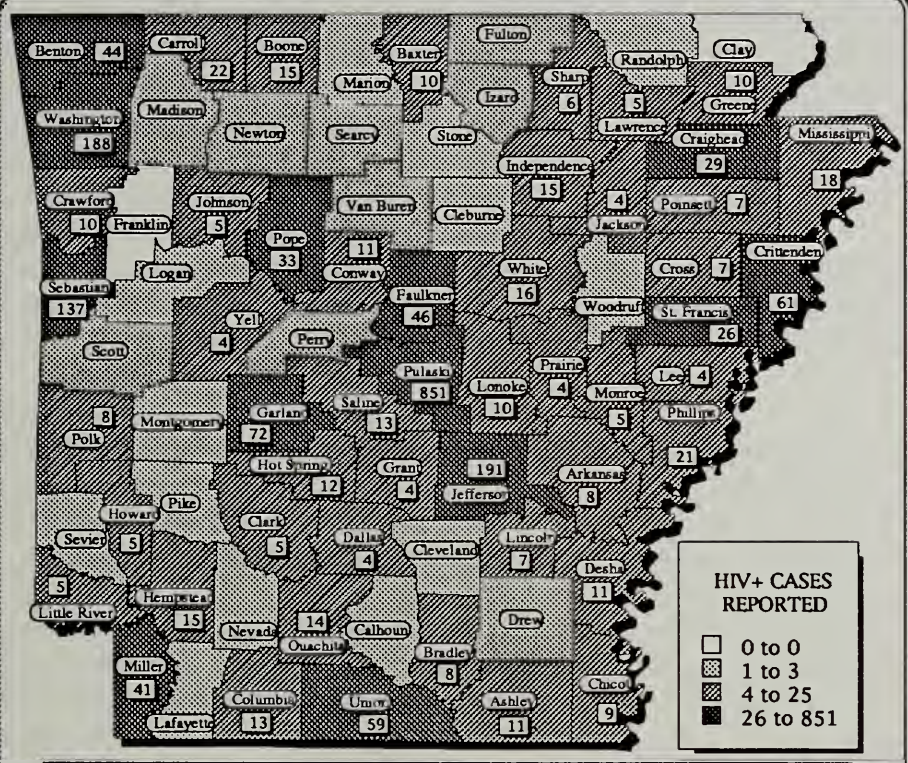
Arkansas: 1983 through January 25, 1993

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	19	32	49	216	251	437	421	408	34	**1,867**	*85.33*
	Female	1	1	6	27	39	72	89	83	6	**324**	*14.81*
AGE	< 5	0	0	1	1	2	9	14	8	0	**35**	*1.60*
	5-12	0	0	0	1	1	5	2	2	0	**11**	*0.50*
	13-19	0	0	0	8	8	14	20	26	2	**78**	*3.56*
	20-29	8	10	15	109	125	192	154	164	14	**791**	*36.15*
	30-39	7	15	22	86	105	206	219	185	16	**861**	*39.35*
	40-49	4	7	11	24	35	62	74	68	7	**292**	*13.35*
	> 49	1	1	6	6	12	19	23	38	1	**107**	*4.89*
	Unknown	0	0	0	8	2	2	4	0	0	**16**	*0.73*
RACE	White	16	24	47	171	178	353	312	302	27	**1,430**	*65.36*
	Black	4	9	8	70	107	153	195	179	11	**736**	*33.64*
	Other	0	0	0	2	5	3	3	10	2	**25**	*1.14*
TOTAL HIV+ CASES BY YEAR		**20**	**33**	**55**	**243**	**290**	**509**	**510**	**491**	**40**	**2,188**	*100%*

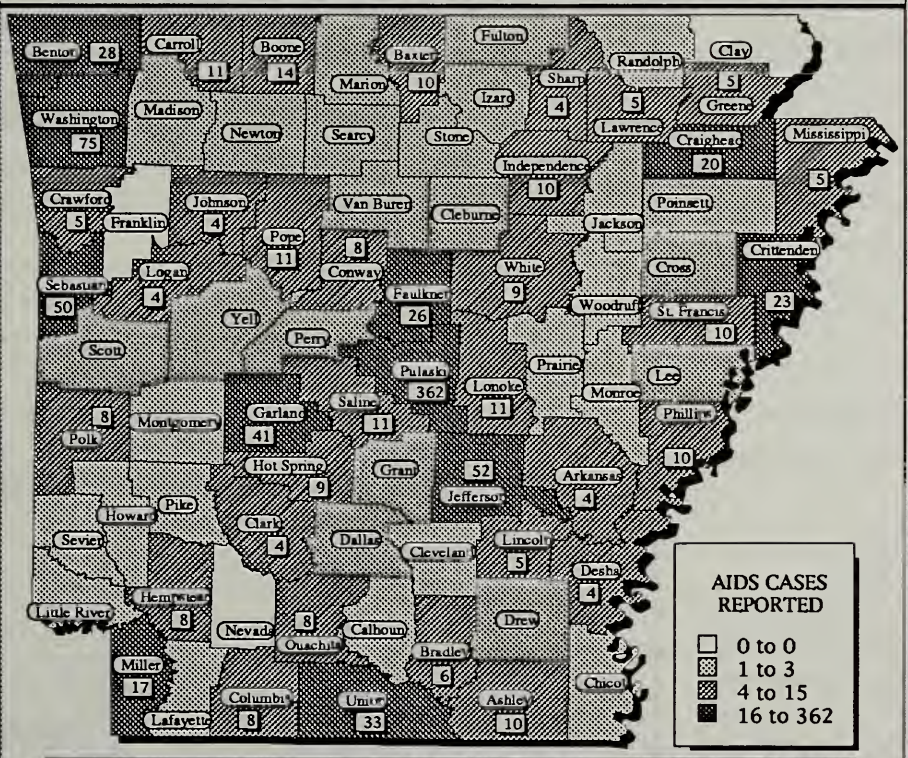
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	83	**911**	*88.36*
	Female	1	0	4	6	10	20	25	35	19	**120**	*11.64*
AGE	< 5	0	0	0	1	1	6	6	3	0	**17**	*1.65*
	5-12	0	0	0	1	0	1	1	0	0	**3**	*0.29*
	13-19	0	0	0	0	0	4	3	2	3	**12**	*1.16*
	20-29	7	9	15	27	24	55	57	81	26	**301**	*29.19*
	30-39	3	13	23	36	41	78	80	128	53	**455**	*44.13*
	40-49	1	6	8	10	7	35	41	52	16	**176**	*17.07*
	> 49	1	0	4	8	7	11	13	19	4	**67**	*6.50*
RACE	White	9	22	43	61	58	141	134	207	77	**752**	*72.94*
	Black	3	6	7	20	21	47	66	74	24	**268**	*25.99*
	Other	0	0	0	2	1	2	1	4	1	**11**	*1.07*
RISK	Male/Male Sex	7	17	31	59	50	118	118	177	54	**631**	*61.20*
	Injection Drug User (IDU)	0	2	10	4	11	18	28	40	15	**128**	*12.42*
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	5	**86**	*8.34*
	Heterosexual	2	0	2	3	6	10	10	22	5	**60**	*5.82*
	Transfusion	0	0	2	7	3	7	11	3	1	**34**	*3.30*
	Perinatal	0	0	0	1	1	6	6	3	0	**17**	*1.65*
	Hemophiliac	0	0	0	1	1	5	5	4	5	**21**	*2.04*
	Undetermined	0	0	1	2	2	8	6	18	17	**54**	*5.24*
TOTAL AIDS CASES BY YEAR		**12**	**28**	**50**	**83**	**80**	**190**	**201**	**285**	**102**	**1,031**	*100%*

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1993



County of residence at the time of test for the 2188 Arkansans reported to be HIV+. (1/25/93)



Of the 2188 Arkansans reported to be HIV+, 1031 have been diagnosed with AIDS. (1/25/93)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Medicine in the News

Health Care Access Foundation Update

As of January 1993, the Arkansas Health Care Access Foundation has provided free medical services to 5,406 medically indigent persons, received 11,038 applications, and enrolled 22,713 persons.

The program has 1,484 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

Dr. James L. Maupin Surgical Suite Opens

The Board of Governors of Dardanelle Hospital announced in February 1993, the opening of the Dr. James L. Maupin Surgical Suite.

AMA Launches New Ad Campaign

The American Medical Association has launched a series of 13 ads in the Washington, D.C. print media. Its purpose: to position the AMA and its Health Access America reform proposal as a comprehensive plan to contain costs, improve access and maintain quality. The ads portray the AMA as working toward serious reform to bring health insurance access to all Americans.

Family Practice Opportunity

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Bush Signs Changes in CLIA Regulations

In his final week in office, President Bush gave his approval to a new waived category for physician-performed tests under the Clinical Laboratory Improvement Amendments. The AMA and a coalition of medical specialty societies had urged the President to authorize the new regulations, which also had been backed by outgoing HHS Secretary Louis Sullivan, M.D.

The AMA already has stated its intent to work with the Clinton Administration to develop additional improvements to CLIA, but also stated that the changes represented a significant first step toward improving the measure.

"Die And Let Live" Airing On PBS

Public television will attempt to clear up some of the mystery surrounding organ transplants with "Die And Let Live", a half-hour special premiering on PBS stations throughout the country Wednesday, May 19. (Check local listings.)

The documentary takes viewers behind the scenes at Dallas' Baylor University Medical Center on a day when doctors transplant the heart, liver and one lung of an 18-year-old woman who died in a car wreck.

26 New Drugs Approved in 1992

America's pharmaceutical research companies in 1992 won approval from the Food and Drug Administration for 26 new drugs, the second highest number approved in the past decade. The most approvals occurred in 1991 and 1985, when 30 new drugs were cleared by FDA.

These new medicines represent significant advances in several therapeutic categories. Many are for serious and life-threatening diseases, including four new medicines for heart diseases, 2 for cancers, and four for AIDS and AIDS-related conditions. Other important approvals were a drug for enlarged prostate, an arthritis medication and an asthma treatment. Also available are four neuropsychiatric drugs: a new treatment for migraine headaches, an anti-depressant, a sleep aid and a diagnostic for central nervous system disorders.

Two drugs were approved for use in surgery - an anesthetic and a skeletal muscle relaxant. Another 5 medicines were approved for infectious disease. Also, a treatment for sun-damaged skin and an oral contraceptive were cleared.

Additional approvals included 6 important biologics - 4 therapeutics and 2 vaccines.

In Memoriam

Augustus Joseph Baker, M.D.

Dr. Augustus J. Baker, of Las Cruces, N.M., a retired radiologist, died Friday, January 29, 1993. He was 86.

Dr. Baker is survived by two daughters, Kathrynanne Minters of Pacifica, California, and Greta B. Allen of Las Cruces; a sister, Helen Suchma of Cleveland, Ohio; and five grandchildren.

Robert Earl Glasscock, M.D.

Dr. Robert Earl Glasscock, of Pine Bluff, an ophthalmologist, died Monday, February 1, 1993. He was 75.

Survivors are his wife, Hay Thomas Glasscock; a son, Robert Glasscock of Hollywood, California; a stepson, Roy C. Turner of Little Rock; a daughter, Dr. Rebecca Glasscock of St. Paul, Minnesota; a sister, Jane Bell of Pine Bluff; and two grandchildren.

Guy U. Robinson, M.D.

Dr. Guy U. Robinson, of Dumas, died Friday, February 5, 1993. He was 69.

Survivors are his wife, Artie Robinson; two sons, Guy Robinson of Jakarta, Indonesia, and Joel Robinson of South Bend, Indiana; two daughters, Janet Baker of Mansfield and Celia Reynolds of Florence, Alabama; a stepson, Guy Teeter of Tillar; a stepdaughter, Susan Fleming of Dumas; a brother, Gale Robinson of Crown Point, Indiana; and five grandchildren.

John Vines Satterfield, M.D.

Dr. John Satterfield, of Little Rock, a thoracic and cardiovascular surgeon, died Sunday, January 31, 1993. He was 60.

Survivors are his wife, Susan Seljgman Satterfield; three sons, John V. Satterfield, Andrew N. Satterfield and Daniel A. Fuller, all of Little Rock; three daughters, Ann D. Satterfield of New York City, Charlotte W. Satterfield and Susan E. Fuller, both of Little Rock; his mother, Thelma Holt Satterfield of Little Rock; two brothers, William W. "Bick" Satterfield of Little Rock and Hammond Satterfield of Atlanta.

Stop by and visit our '93 exhibitors on Thursday, April 15 and Friday, April 16!

117th Annual Session • Arlington Hotel • Hot Springs

The Odds are in Your Favor!

Don't miss the chance to get away and have some fun while you attend the Arkansas Medical Society annual convention!!

Golf Tournament for Members and Exhibitors on Thursday morning ◆ Welcome reception on Thursday afternoon, followed by the 1st House of Delegates ◆ Blue Cross Blue Shield Reception on Thursday evening ◆ Shuffield Luncheon on Friday at noon ◆ A Western Hoedown on Friday evening ◆ Exhibits and CME Sessions on Thursday and Friday ◆ The Final House of Delegates on Saturday morning ◆ Derby Day at Oaklawn on Saturday afternoon ◆ The AMS Inaugural Banquet on Saturday evening, followed by the President's Reception.

"On the Right Track"

Arkansas Medical Society
117th Annual Session
Arlington Hotel Hot Springs
April 15 - 17, 1993

New Members

BENTON COUNTY

Mishkin, David, Anesthesiology, Fayetteville. Born July 13, 1928, Chicago. Medical education, University of California, 1955. Internship, Zieger Hospital, Detroit, 1956. Residency, Highland Hospital of Alameda County, 1965. Board certified.

CRITTENDEN COUNTY

Kaplan, Bertram D., Dermatology, West Memphis. Born November 1, 1948, Englewood, New Jersey. Medical education, Jefferson, Philadelphia, Pennsylvania, 1974. Internship/Residency, Duke University, 1978. Practice experience, 15 years. Board certified.

DALLAS COUNTY

Dallaire, Robert, General Practice, Fordyce. Born February 3, 1949, Quebec, Canada. Medical education, Sherbrooke University, Quebec, 1973. Internship, Enfant Jesus Hospital, 1974. (Rotatory 1 year). Practice experience, 19 years. LMEE, Canada, 1974.

GARLAND COUNTY

Handleman, Marshall J., Neurology, Hot Springs. Born October 16, 1939, Baltimore. Medical education, University of Miami, School of Medicine, 1965. Internship, Columbus Medical Center, Columbus, Georgia, 1966. Residency, Los Angeles County USC Medical Center, 1979. Practice experience, 22 years. Board certified.

JACKSON COUNTY

Fremming, Bret G., General Practice, Newport. Born November 5, 1958, Pittsburgh. Medical education, University of Texas Medical Branch, 1987. Internship, OU, Tulsa, 1988. Practice experience, 5 years.

JEFFERSON COUNTY

Nagappa, Champa, Pediatrics, Pine Bluff. Born March 15, 1948, India. Medical education, Karnatale Medical College, India, 1971. Internship/Residency, India, 1981. Practice experience, 12 years.

LAWRENCE COUNTY

Boozer, Ann G., General Surgery, Walnut Ridge. Born August 10, 1957, Atlanta. Medical education, Tulane University, 1983. Internship, Charity Hospital - Tulane Division, 1984. Residency, Tulane University Affiliated Hospitals, 1988. Practice experience, 4 years. Board certified.

PHILLIPS COUNTY

Tucek, Ladd T., Otolaryngology, Helena. Born January 16, 1935, Chicago. Medical education, Chicago College Osteopathic Medicine, 1961. Internship, Green Cross General Hospital, 1961. Residency, Tulsa Regional Medical Center, 1973. Practice experience, 31 years. Board certified.

PULASKI COUNTY

Agnew, Samuel G., Orrthopaedic Traumatology, Little Rock. Born October 22, 1958, New Orleans. Medical education, Tulane University school of Medicine, 1984. Internship, Tulane University Affiliated Hospital, 1985. Residency, Medical University of South Carolina, 1989. Practice experience, 3 years. Board certified.

Jackson, Richard J., Pediatric Surgery, Little Rock. Born Decembeer 13, 1956, Atlanta. Medical education, West Virginia University School of Medicine, 1983. Internship/Residency, West Virginia University Hospitals, 1984. Residency, Fellowship Children's Hospital of Pittsburgh, 1992. Practice experience, 1 year. Board certified.

Moutos, Dean M., Obstetrics & Gynecology, Little Rock. Born March 31, 1959, Bethesda, Maryland. Medical education, University of Texas, 1985. Internship/Residency, University of Oklahoma, 1989. Practice experience, 1 year.

Mumme, David R. Jr, Anesthesiology, Little Rock. Born June 29, 1960, Houston. Medical education, University of Texas Health Science Center, San Antonio, 1988. Internship/Residency, Mayo Clinic (Graduate School of Medicine), 1992. Practice experience, 1 year. Board certified.

Shewmake, Kristopher B., Plastic and Reconstructive Surgery, Little Rock. Born August 10, 1955, Charlotte. Medical education, UAMS, 1984. Internship/Residency, UAMS, 1992. Board eligible.

SEBASTIAN COUNTY

Frederick, James A., Internal Medicine, Fort Smith. Born October 14, 1946, Jamestown, North Dakota. Medical education, University of Minnesota Medical School, 1972. Internship, St. Paul-Ramsey Hospital, 1973. Residency, University of North Dakota Internal Medicine, 1979. Practice experience, 20 years. Board certified.

SHARP COUNTY

Van Ore, Stevan M., Family Practice, Cherokee Village. Born October 4, 1943, Seneca Falls, New York.

Medical education, University of Miami, 1970. Internship/Residency, Orlando, Florida, 1972. Practice experience, 21 years. Board certified.

UNION COUNTY

Jenkins, Chester W., Psychiatry, El Dorado. Born November 12, 1942. Medical education, Medical College of South Carolina, 1968. Internship, University Hospital, Augusta, Georgia, 1969. Residency, Medical College of Georgia, 1972. Practice experience, 21 years. Board certified.

RESIDENTS

Ahmad, Razee A., Internal Medicine. Born November 1, 1964, Pakistan. Medical education, Dow Medical College, Pakistan, 1989. Internship, Albert Einstein College of Medicine, New York. Residency, UAMS.

Biernat, Elzbieta J., Anesthesia. Born January 21, 1956, Warsaw, Poland. Medical education, Medical Academy in Warsaw, 1980. Internship/Residency, UAMS.

Clark, Marilyn K., Internal Medicine. Born May 6, 1957, Kansas. Medical education, Baylor College of Medicine, Houston, 1991. Internship/Residency, UAMS.

Kim, Woong R., Internal Medicine. Born March 24, 1962, Seoul, Korea. Medical education, Seoul National University, 1982. Internship/Residency, UAMS.

Lakhanpal, Suresh K., Radiology. Born October 30, 1965, Montreal. Medical education, McGill University, Montreal, 1987. Residency, UAMS.

Munshi, Medha, Endocrinology. Born May 2, 1963, India. Medical education, Baroda Medical College, India, 1985. Internship/Residency, Ball Memorial Hospital, India. Fellowship, UAMS.

Nopper, Amy J., Pediatrics. Born October 28, 1965, Berea, Ohio. Medical education, University of Missouri, 1990. Internship/Residency, UAMS.

Randall, John K., Dermatology, Hot Springs. Born February 4, 1958, Canton, Ohio. Medical education, NEOUCOM, 1986. Internship, St. Thomas Medical Center. Residency, University of Minnesota. Fellowship, Stough Medical Associates.

Simpson, Steve L., Family Practice. Born April 25, 1965, Jonesboro. Medical education, UAMS, 1991. Internship/Residency, AHEC, Jonesboro.

MEDICAL STUDENTS

Arnold, David T.
Bowden, Marcia R.
Franklin, Sherrie R.
Partridge, Paige M.
Reed, Jason T.
Shoppack, Jon P.
Singleton, Kenneth G.
Sutterfield, Vikki L.
Williams, Nancy K.

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AMS Newsmakers

Dr. Jane F. Miers, a pediatrician of Sherwood, has been elected to fellowship in the American Academy of Pediatrics.

Dr. Samuel Koenig, of Family Medical Care in Fort Smith, has been appointed to the College of American Pathologists Commission on Quality Assurance.

Dr. Lander Smith, a general practitioner of Conway, has been elected chief of staff for a two-year term by members of the Conway Regional Hospital medical staff.

Dr. Austin Smith, a retired physician from Huntsville, was named outstanding citizen by the Chamber of Commerce for starting the health care system in Madison County.

Dr. Michael Tedder, a family practitioner of Jonesboro, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Dr. R. Timothy Webb, a specialist in the fields of Hematology and Medical Oncology, and **Dr. James M. Arthur,** a Neurological Surgeon, have been appointed chairmen of the Departments of Medicine and Surgery, respectively, for 1993, at St. Joseph's Regional Health Center, Hot Springs Village.

Dr. John B. Weiss, a cardiovascular surgeon in Springdale, has been elected chief of staff at Springdale Memorial Hospital. **Dr. Terryl J. Ortego,** a gastroenterologist, will serve as vice chief of staff and **Dr. William McGowan,** a family practitioner, as medical staff secretary.

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Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

HISTORY:

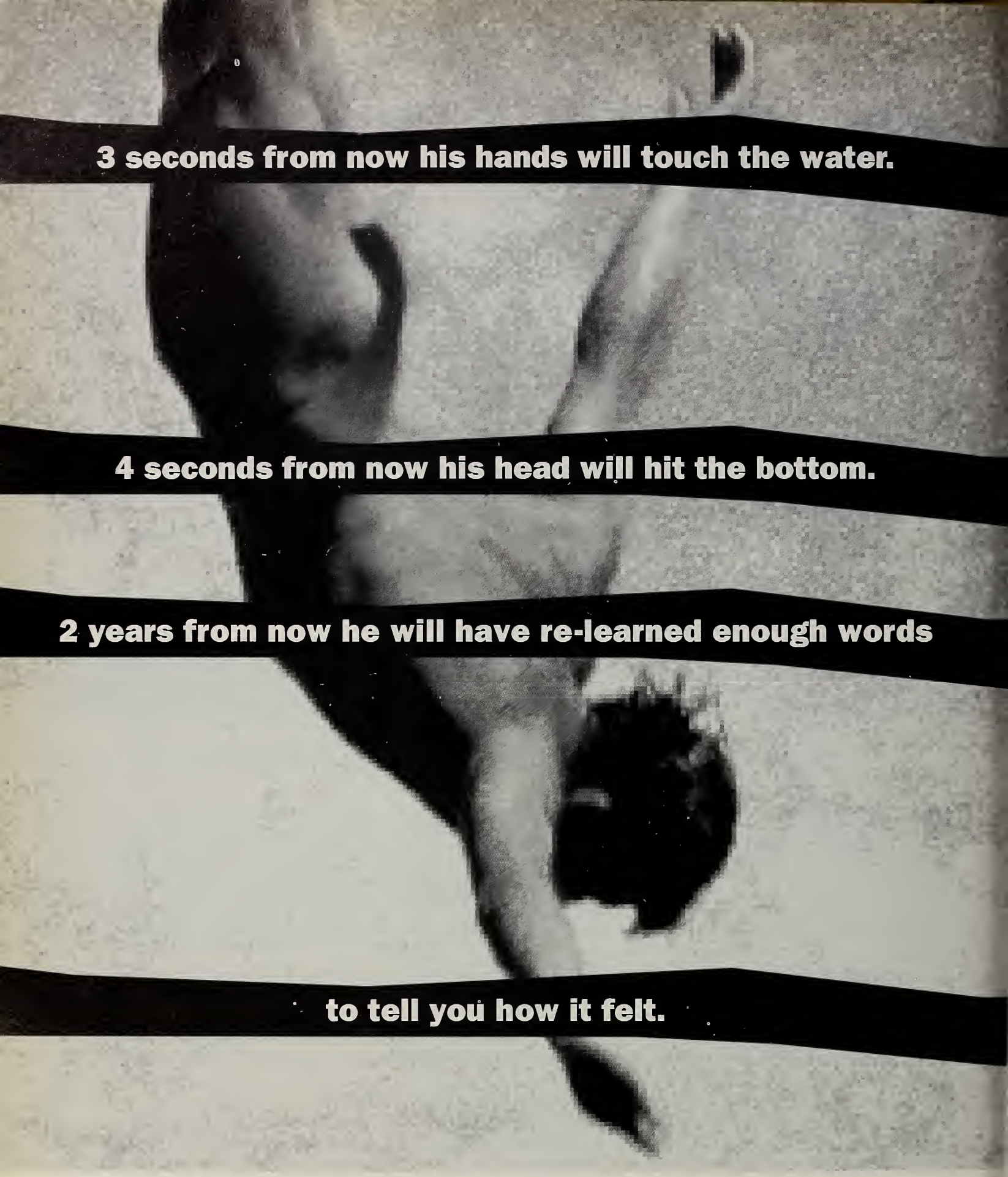
This record was obtained from a 77 year old male who was admitted of near syncopal episodes. These episodes were associated with a sensation that his heart was stopping and that death was eminent. He was on no cardioactive medications. His resting 12 lead electrocardiogram revealed normal sinus rhythm with a heart rate of 80 beats per minute (bpm). Complete right bundle branch block (CRBBB) and left anterior hemiblock with a PR interval of 180 msec (0.18 sec) was present. The tracing below was obtained from telemetry. Does this recording suggest the need for permanent pacing?

DISCUSSION:

The record begins with a sinus complex conducted with CRBBB and a PR interval of 160 msec. The second QRS complex is conducted with a complete left bundle branch block (CLBBB) morphology. The PR interval associated with this complex is 200 msec. The next P wave is not conducted. The third QRS has CRBBB morphology and is preceded by a sinus P wave with a PR interval of 180 msec. The following P wave is not conducted. A repeating pattern of CRBBB, CLBBB, nonconducted P wave, CRBBB, nonconducted P wave is noted. The differential diagnosis for the CLBBB complex is always slightly shorter than P-P intervals associated with CRBBB. It would be unlikely that a premature atrial event would always occur before a premature ventricular event. This observation makes aberrant conduction the most likely explanation. The patient is demonstrating disease of both bundle branches. The longer PR interval in the CLBBB complexes reflects an increase in conduction time through the His-Purkinje system and bundle branches. This varying pattern of conduction through the bundles is called alternating bundle branch block (alt-BBB).

Patients who demonstrate Alt-BBB fall into two categories. The first group show beat to beat variation in BBB. These patients are at high risk of developing complete AV block and syncope. Patients in this category, such as the one under discussion, have markedly prolonged conduction times through the His-Purkinje system. His-Purkinje conduction times tend to be $\geq$ 100 msec (normal value < 65 msec). Another group of Alt-BBB patients show varying BBB on different days. These patients are probably at lower risk of developing complete heart block. Some of the second group of Alt-BBB patients have been followed for several years without developing complete heart block or the need for pacing. Patients demonstrating alternating BBB should be evaluated by Holter monitoring or electrophysiologic testing, if warranted, to evaluate the conduction system. Those with beat to beat alternation of the QRS complexes should be strongly considered for pacing.

This record and discussion were provided by Robert M. Redd, M.D.



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Radiological Case of the Month

Donna Johnson, M.D.
David Harshfield, M.D.

History:

The patient was a 65 year old male who originally presented to the hospital with symptomatology of DVT and pulmonary embolus. Documentation of the thrombosis in the lower extremities was made by duplex ultrasound and performance of pulmonary arteriography documented the pulmonary embolus. The patient was started on anticoagulation therapy, but after several days developed hematemesis and was declared a contraindication for further anticoagulation. A vena cava filter was placed in the inferior vena cava. While on the ward a subclavian line was required. During the course of the subclavian line placement, the guidewire could not be extracted from the patient. Obtaining this portable supine abdomen film revealed the problem.

Figure 1

Inadvertant Guidewire Entrapment by IVC Filter during Subclavian Line Placement.

Findings:

The large arrowheads point to the LGM (Vena-Teck, Fabrique par LG medical) type vena cava filter. The arrows point out the course of the subclavian kit guidewire which was passed distally such that the J-tip became inadvertently lodged in the vena cava filter. Astutely, the clinician choose not to pull on the guidewire and instead utilized this portable abdominal film to document the problem. The patient was sent to the special procedures suite and under fluoroscopic guidance the guidewire was easily removed without displacement of the vena cava filter.

Discussion:

As the ease of introduction of vena cave filters has progressed, there are many more patients who receive them when they are at risk for anticoagulation and have deep venous thrombosis of the lower extremities or pulmonary embolus. Many IVC filters can be place percutaneously via the femoral vein, through a 10f to 12f sheath. Due to the increasing number of patients with caval filters, it will not be unusual to encounter problems of this type when subclavian or internal jugular lines are placed on the ward without the benefit of radiographic control. As dobhoff tubes and subclavian lines continue to be placed in greater numbers without radiographic control, this case points out the importance of using fluoroscopy or other means when any complications or untoward events arise.

Editor: Donna Johnson, M.D., a chief resident at the University of Arkansas for Medical Sciences.

Contributor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.

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Things To Come

April 2-3

Ambulatory Pediatrics. Sacramento Inn, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

5th Annual Rae R. Jacobs Memorial Lecture: Back Pain. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the University of Kansas Medical Center-Department of Surgery, Section of Orthopedic Surgery. CME accreditation offered. For more information, call (913) 588-4488.

Fighting for Their Lives: You Can Make A Difference - HIV Update. Cancer Center Auditorium, UC Davis Medical Center, Sacramento, CA. Sponsored by the Office of Continuing Medical Education at the University of California, Davis School of Medicine and Medical Center. CME accreditation offered. For more information, call (916) 734-5390.

April 8-9

Hands-On Workshop on Advanced Diagnostic Methods in Andrology. Jones Institute of Reproductive Medicine, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 15-18

Thirteenth Annual National Pediatric Infectious Disease Seminar and Special Session on A Malpractice Claim Seems Likely: What Should You Do? Hyatt Regency, New Orleans, LA. Sponsored by the Department of Pediatrics, Southwestern Medical School, The University of Texas Southwestern Medical Center. CME accreditation offered. For more information, call Marian Troup at (214) 688-8845.

April 16-18

43rd Annual Postgraduate Symposium on Anesthesiology. Ritz-Carlton Hotel, Kansas City, MO. Sponsored by the Department of Anesthesiology, the University of Kansas Medical Center. CME accreditation offered. For more information, call (913) 588-4488.

April 18-20

13th Annual Meeting of the American Society for Laser Medicine and Surgery. Marriott Hotel, New Orleans, LA. CME accreditation offered. For more information, call (715) 845-9283.

First Annual Update Course in Gynecology. Grand Hyatt Hotel, New York, NY. 13.5 hours Category I CME credit offered. A reduced tuition fee of $445 will be offered through March 1. For more information, call (201) 385-8080.

April 21-25

Seventh Annual Critical Care Update. Hyatt Regency-Capitol Hill, Washington, D.C. 35 hours Category I CME credit offered. For more information, call (201) 385-8080 or (800) 231-0389.

April 23

Thrombolysis: Its Role in Peripheral, Arterial and Venous Disorders. Omni International Hotel, Norfolk, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 23-24

5th Annual Pediatrics & All That Jazz: Current Practice and Recent Advances. Brent House Hotel, New Orleans, LA. Sponsored by the Alton Ochsner Medical Foundation, New Orleans. For more information, call (504) 842-3702.

29th Annual Orthopaedic Symposium - Diagnosis and Treatment of Diseases of the Cervical Spine. The Houstonian Hotel and Conference Center, Houston, TX. Sponsored by St. Luke's Episcopal Hospital. For more information, call (713) 791-4200.

April 24

Hemodynamic Monitoring in Anesthesia and Intensive Care. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. 6.5 credit hours AMA Category I offered. For more information, call (800) 325-9862.

April 26-30

Radiation Safety Instrumentation & Compliance. Sheraton Plaza Hotel, Orlando, FL. Sponsored by Oklahoma State University Division of Engineering-Technology. Fees: $850. For more information, call (405) 744-5714.

April 29-May 1

12th Annual Conference on Child Abuse and Neglect. Red Lion Inn, Sacramento, California. Sponsored by Office of Continuing Medical Education, University of California-Davis School of Medicine and Medical Center. 12 hours Category I CME credit offered. For more information, call (916) 734-5390.

19th Annual Meeting of the Federated Ambulatory Surgery Association. Sheraton Harbor Island Hotel, San Diego, CA. For more information, call (703) 836-8808.

April 29-May 2

Clinical Electrocardiography: Basic Concepts & Interpretation - 13th Edition. Ritz-Carlton Hotel, Philadelphia, PA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 30-May 1

Hearing Aid Conference. Frontenac Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

April 30-May 2

Pathology of HIV. Arlington, VA. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, (202) 992-4285.

April 30-May 3

Annual Clinical Research Meeting. Washington, D.C. Sponsored by the Association of American Physicians, The American Society for Clinical Investigation, and the American Federation for Clinical Research. For more information, call (609) 848-1000.

May 5

Update in Thoracic Surgery. Washington University Medical Center, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

May 6-9

Practical Dermatology for the Primary Care Physician - 19th Edition. Ritz-Carlton Hotel, Pentagon City, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

May 13

Current Perspectives in Menopausal Problems. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

May 13-16

Central Atlantic Seminar in Anesthesiology. Washington, D.C. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

May 21-22

Third Annual Cardiovascular Disease Review and Update For Primary Care Practitioners. Drake Hotel, Chicago, IL. Sponsored by Rush Medical College. 11.5 hours of Category I CME credit offered. For more information, call (201) 385-8080.

June 3-5

3rd International Biological Effects of Light Symposium. Wenkenhof Riehen meeting Center, Basel, Switzerland. Sponsored by the Light Symposium Foundation. For more information, call (404) 432-2409.

June 6-11

9th Annual EVMS Family Medicine Review Course. The Cavalier Hotel, Virginia Beach, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

June 11-12

Alzheimer's Disease. Adam's Mark Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

June 12-16

Board Review in Family Practice. Arlington, VA. Sponsored by The George Washington University Medical Center. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

June 13-18

17th Annual Fingers to the Toes: Primary Care Orthopaedics. Fallen Leaf Lake (South Lake Tahoe), CA. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. CME credit offered. For more information, call (916) 734-5390.

June 17-18

Allergic Diseases of the Upper and Lower Airways. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

June 25-27

11th Summer Symposium in Internal Medicine. Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

July 6-10

16th Annual Flap Dissection Workshop. Virginia Beach Conference Center, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

July 21-25

15th Annual National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum. Houston, TX. Sponsored by The George Washington University Medical Center Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of Continuing Medical Education, (202) 994-4285.

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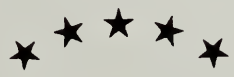

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Keeping Up

Critical Care and Emergency Medicine
April 1-3, 7:00 a.m., Arlington Hotel, Hot Springs. Sponsored by UAMS College of Medicine and presented by Milton D. Deneke, M.D. & Terry Yamauchi, M.D. 11.5 hours Category I credit are offered. Fee - $200.

Multi Drug Resistance Tuberculosis Conference
April 2, 8 a.m. - 4 p.m., auditorium of the Arkansas Department of Health, Little Rock. Co-sponsored by the Arkansas Dept. of Health, Division of Public Health Laboratories and the National Laboratory Training Network. Registration required. For more information, call Division of Public Health Laboratories at 661-2363.

Infectious Disease Update
April 2 & 3, 7:30 a.m. - 12 noon, The Park Hilton, Hot Springs. Sponsored by Arkansas Children's Hospital, Department of Pediatrics/UAMS. CME Category I credit available. Fee: $100.

Anesthesiology Update
April 3, 7:15 a.m. - 5:00 p.m., Holiday Inn West, Little Rock. Sponsored by UAMS College of Medicine and presented by Richard B Clark, M.D. CME credit offered. Fee: $50 for non-members.

Arkansas Society of Anesthesiologists Meeting
April 3, 7:45 a.m. - 4:45 p.m., Holiday Inn West, Little Rock. Sponsored by UAMS Department of Anesthesiology. Topic: "Obstetrics Anesthesia Update," presented by Richard Clark, M.D. Call (501) 686-6125 for more information.

Laparoscopically Vaginal Hysterectomy
April 10, 8:00 a.m., UAMS Education II Building, Little Rock. Sponsored by UAMS and presented by Karen Kozlowski, M.D. 5 hours Category I credit, $300 fee.

Common Clinical Problems in the Elderly
April 13, 8:00, Excelsior Hotel, Little Rock. Sponsored by UAMS and presented by David A. Lipschitz, M.D., Ph.D. and Ronnie Chernoff, Ph.D., R.D. 6 hours credit. Registration fee: $75; V.A. employees: $55.

Annual W.W. Stead Chest Symposium
April 24-25, 7:30, Fairfield Bay Resort and Conference Center. Sponsored by UAMS and presented by Marcia L. Erbland. 7.25 Category I credit. Fee: Physicians, $50; Others, $25.

Annual Family Practice Intensive Review
April 30-May 2, time to be announced, UAMS Education II Building, Little Rock. Sponsored by UAMS and presented by R. Jerry Mann, M.D. and Mary Lindsey, L.C.S.W. Approximately 20 hours Category I credit. Standard fee: $300; Early fee (before April 14): $275.

Family Medicine Spring Academic Conference
May 21-23, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

UAMS College of Medicine Alumni Weekend
June 11-13, Capital and Excelsior Hotels, Little Rock. Sponsored by the Arkansas Caduceus Club, College of Medicine Alumni Association. For more information, call (501) 686-6684.

46th AAFP Annual Scientific Assembly
July 29-August 1, Excelsior Hotel and Statehous Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE-VA MEDICAL CENTER
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER
CME Luncheon for Medical/Dental Staff, Mar. 12 & 26, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon
CME Luncheon, April 9 & 23, May 14 & 28, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL
Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
(THE AIDS CONFERENCE FOR APRIL IS CANCELLED FOR GOOD FRIDAY)

LITTLE ROCK-BAPTIST MEDICAL CENTER
Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL
Chest & Problems Case Conference, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Medicine Conference, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.
Surgery Conference, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Tumor Conference, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29

GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, 4th Thursday, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Pre-op/Didactic Conference, Mondays, 5:00 p.m., VAMC-LR, 4D
Urology Radiology Conference, 1st Thursday, 5:00 p.m., UAMS, Radiology Department
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Urology VA Teaching Rounds, every Friday, 7:30 a.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO-AHEC
Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital

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SUPERBILL PPO
WORKMAN'S COMP
ICD DIAGNOSIS CODES
REFERRING PHYSICIAN SECONDARY
GROUP NUMBER HICFA
PLACE OF SERVICE CODE
PRIMARY CARRIER
PRIOR AUTHORIZATION
TYPE OF SERVICE CODES
SAME/SIMILIAR INDICATOR
PATIENT CHARTS DAY SHEETS
SUPERBILL
CPT PROCEDURE CODES
WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN
ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE
DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT
APPROVED AMOUNT TYPEWRITER
CODING REQUIREMENTS
APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES DATE OF DISABILITY
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Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC - South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

FAYETTEVILLE-AHEC NORTHWEST
AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH-AHEC
Advances in Plastic Surgery, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith
Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Osteoporosis, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith
Sparks Tumor Conference, Tuesdays, 12:00 noon, Sparks Regional Medical Center
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST
AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC
Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST
Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General.**)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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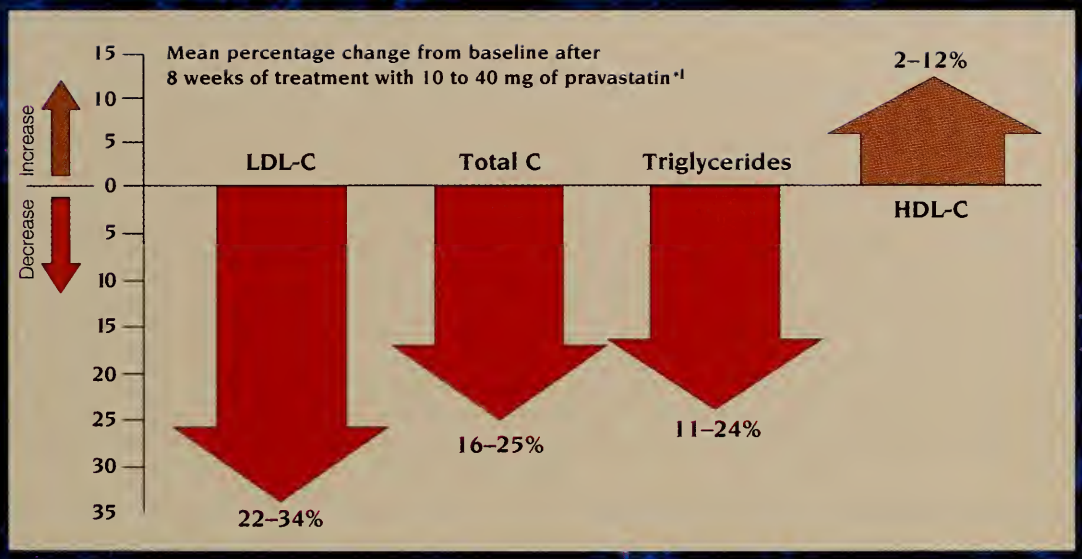

*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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Volume 89 Number 11 April 1993

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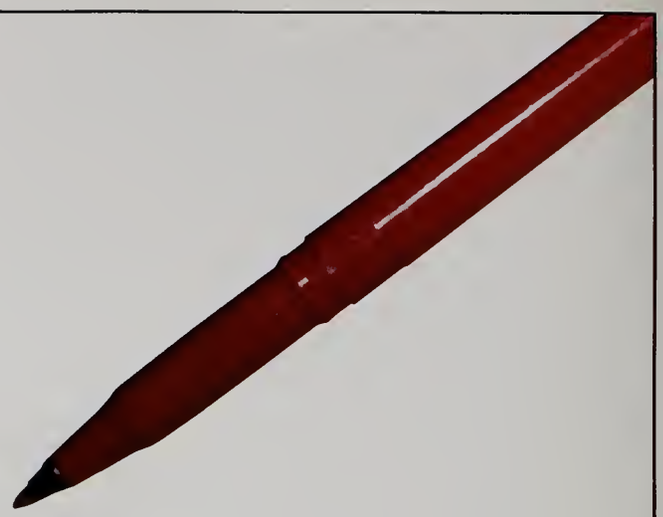

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 89 Number 11 *April 1993*

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Cover photo by Brian Moore, Arkansas Dept. of Parks & Tourism.

Better Compliance and Medicine Use: Making It Happen

Robert M. Bachman*

Imagine a public health scenario in which health professionals regularly counseled patients about their prescriptions, and virtually all patients took their medications as prescribed. Think about the profound impact these behaviors would have on health outcomes, patient well-being, health care utilization and costs, and employee productivity. This dramatic vision of a healthier America, which requires no new medical breakthroughs to achieve, is a powerful motivation for change.

With noncompliance averaging 50% today, and 70% of patients reporting inadequate medicine counseling, is this vision within our reach? Can we overcome problems that are as old as the practice of medicine?

The National Council on Patient Information and Education (NCPIE) believes the answer to both questions is YES. For the past 10 years, the 260 health professional, government, consumer, and industry organizations that make up the Council have taken hundreds of positive steps to improve medicine use. Our primary focus: to improve patient-professional communication about prescription medicines. As a result of this decade of action, America has shown that it has what it takes to make a new kind of health breakthrough, whose importance cannot be overstated. Three critical advances underlie today's opportunities:

1. We now understand the complexity of the compliance problem. Patient communication and treatment compliance are personal actions that depend on human knowledge, attitudes, and behavior patterns. After 10 years of exploration and research synthesis, we have a much clearer picture of the complex context within which medicine use occurs. By recognizing key variables, health care providers can tailor compliance-promotion activities to meet specific needs. For example, targeting can occur:

- *By patient group.* Medicine use issues vary by age, sex, and educational status. Some examples:

CHILDREN (0-18) rely on parental supervision and monitoring of medicine use, but they also need role models, education, and encouragement to develop good medicine habits.

WORKING AGE ADULTS (19-64) are the largest population using medicines, but many have negative attitudes about taking them. They want more information about medicines, and they need it: improper medicine use costs employers and the economy millions of dollars each year.

OLDER ADULTS (65 and over) use the greatest proportion of medicines. Improving their health through proper medicine use involves overcoming a variety of age-related communication, physiologic and health system barriers.

WOMEN take more medicines than men. They have special needs related to reproduction and unique medicine concerns at each stage of life. Women also often assume the role of family medicine manager/caregiver and must have accurate information on the medicines of those they care for.

LOW-LITERATE patients need special types of communication and support for proper medicine use.

- *By health profession.* Pharmacists, physicians, nurses and other health professionals each have different potential roles in, and barriers to, patient communication and compliance-promotion. For example, most patients prefer to get medicine information from their physician at the time of diagnosis and prescribing. Pharmacists have the "teachable moment" in medicine counseling. When patients get to the pharmacy, they may ask questions they forgot to ask the doctor or want advice on compliance aids the pharmacy sells.
- *By setting.* Hospitals, private and group physician practices, managed care organizations, community

* Robert M. Bachman is executive director for the National Council on Patient Information and Education.

pharmacies, worksites and community groups can all contribute to better medicine use. But their systems are unique and their roles can vary.

- *By disease(s).* Each health problem requiring medicine therapy has specific priorities and problems. Studies show, for example, that failure to complete antibiotic therapy can be a significant acute care problem. Chronic diseases and multiple medicine use present even greater compliance difficulties. While the multi-dimensional nature of the problem is a challenge, it is also an opportunity for collaborative action. Many players and many approaches can combine to create solutions.

2. We have the momentum; safe and effective medicine use is becoming a national health priority. Over the years, many concerned researchers, health care organizations and companies, health professionals, educational programs, and consumers have worked individually to try to solve compliance problems. Until recently, however, educational and behavioral issues have received fragmented attention, often as a subsidiary component of a disease-specific intervention.

Today, however, better communication and compliance are becoming a national health priority. The following examples illustrate the broad-based momentum for change.

- U.S. Food and Drug Administration (FDA) Commissioner David Kessler has called for a national professional education initiative to promote better patient-professional communication about medicine. In a recent article in the *New England Journal of Medicine*, he stated that, "the FDA cannot ignore the large-scale inappropriate use of drugs whose safety and efficacy are its responsibility." Dr. Kessler challenged health professionals to take responsibility for giving patients the verbal and written medicine information they need. "In my view," Dr. Kessler asserted, "bridging the information gap is a matter of high priority for consumers, providers and the FDA." Dr. Kessler has emphasized NCPIE's role in the collaborative process, as well as the potential for computer technology to efficiently supplement verbal counseling from health professionals.
- The U.S. Department of Health and Human Services (DHHS) in its 1991 report "Healthy People 2000, National Health Promotion and Disease Prevention Objectives," has set many goals for the nation's health that depend on better medicine use. Three objectives focus directly on the safe use of medicines, including increasing communication between health care providers and older patients and taking actions to avoid drug interactions and overdoses.

DHHS Secretary Dr. Louis Sullivan has also emphasized these priorities through his active support of NCPIE initiatives such as the *National Brown Bag Medicine Review Program* and the "Speak Up for Children" campaign to improve children's medicine use.

- State medical societies have begun sponsoring

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"brown bag" programs, urging physicians to conduct medicines reviews for their patients, especially older adults.

- National physician organizations have developed programs to help their members communicate with patients more effectively.
- The standards of practice for the profession of pharmacy now include statements about the pharmacist's responsibility for giving information to patients.
- The U.S. Congress recognized the role that pharmacists can offer in counseling patients through the recently enacted federal legislation entitled, The Omnibus Budget Reconciliation Act of 1990.
- At least 21 states have adopted requirements that pharmacists counsel all patients, not just Medicaid recipients.

These trends all reflect the increasing emphasis placed on safe and effective medicine use in the nation's health agenda.

3. We have the tools and resources to enable improvement. During the past 10 years, concerned organizations have developed an enormous number of programs and products that facilitate information, education and compliance, including: written patient and professional education materials targeted to every audience, including those with low literacy skills; interactive tools, such as patient contracts; audiovisual and computer-aided patient education products; high- and low-tech compliance aids; written and computerized reference materials for health professionals; software systems that facilitate pharmacy monitoring for drug interactions and compliance; innovative professional education programs that build key communication skills; research-based reports exploring the problem and its solutions; and media approaches to raising public awareness of the issue. This rich resource base provides the tools and the techniques that can create positive change.

Taking Action

How can these advancements be used to ensure that patients get the information they need to use their medicines safely and effectively? FDA Commissioner Kessler says that improving communication "is not a matter of principle, but of implementation." While few dispute the need, he says, only committed, concerted action will make it happen.

The slogan "Communicate Before You Medicate," is a simple statement with profound implications for every major public health problem - and every household - in America. Today's health care providers have got what it takes to make this slogan a reality. With the will and commitment to use it, the impact on American health can be revolutionary.

To Achieve Better Compliance

WE MUST IMPROVE:

Patient Knowledge About Medicines

In recent surveys and studies:

- 50% of patients didn't know the correct dose of their medicine.
- 38% didn't know the correct timing of their doses.
- 69% were not well-informed about potential side effects.

Consumer Attitudes About Medicines

- More than 60% are "highly concerned" about dependence on medications, taking unneeded medications, and society's being "overprescribed."
- 80% of consumers say they take less medicine than the doctor prescribes.
- 10% of consumers ages 25-43 say they avoid medicines altogether.

The Quality of Patient-Professional Interactions

- 72% said they were inadequately informed about medicines in general.
- In a series of 221 patient interviews, only 19 patients said their physician had asked if they had questions.
- Patients sometimes report distracting health professional behaviors, such as: being cut off in mid-sentence; lack of eye contact; or the professional looking at his/her watch while the patient is speaking.

BARRIERS WE FACE:

In a 1992 survey, NCPIE members listed the following barriers most often:

- The health care professional's lack of time to counsel patients.
- Health facilities generally aren't designed to support education and counseling (e.g., high counters between pharmacists and patients, lack of AV and computer equipment in physicians' offices).
- Lack of reimbursement for patient education, particularly for pharmacists.
- Lack of emphasis on medicine communication issues in both health professional training and public schools.

ENCOURAGING TRENDS:

- Most patients say they want more information about their medicines.
- Most physicians and pharmacists believe communication is important. During the typical 10-hour workday, independent retail pharmacists spend 18% of their time (nearly two hours) counseling patients. They also call physicians 13 times a day and receive at least 10 calls from physicians.
- Consumers believe physicians and pharmacists are the most credible sources of medicine information. Pharmacists most often counsel patients about side effects, use of alcohol, timing of dosage, and how to administer.

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SHUFFIELD LUNCHEON ON FRIDAY AT NOON ◆ A WESTERN HOEDOWN ON FRIDAY EVENING ◆ EXHIBITS AND CME SESSIONS ON THURSDAY AND FRIDAY.

THE FINAL HOUSE OF DELEGATES ON SATURDAY MORNING ◆ DERBY DAY AT OAKLAWN ON SATURDAY AFTERNOON ◆ THE AMS INAUGURAL BANQUET ON SATURDAY EVENING, FOLLOWED BY THE PRESIDENT'S RECEPTION.

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On the Right Track

1993 AMS Convention Program

Arlington Hotel Hot Springs, Arkansas April 15 - 17, 1993

Thursday, April 15, 1993

9:00 a.m.
Golf Tournament
Sponsored by Schering Corporation

1:00 p.m. - 5:00 p.m.
Registration

2:30 p.m.
Council Meeting

3:30 p.m.
Welcome Reception
1st Exhibit Time
Sponsored by Worthen National Bank of Arkansas

5:00 p.m.
House of Delegates
Speaker to be announced

6:30 p.m.
Blue Cross Blue Shield Reception
By the Pool Deck - Dress is Casual

Friday, April 16, 1993

7:30 a.m. - 4:30 p.m.
Registration

7:30 a.m.
Council Meeting

8:00 a.m.
Continental Breakfast
2nd Exhibit Time

10:00 a.m.
Reference Committees

11:00 a.m.
"The Effect of CLIA on Your Practice"
Paul Bachner, M.D.
Department of Pathology and Laboratory Medicine
United Hospital Medical Center
Port Chester, New York

12:30 p.m.
Shuffield Luncheon/Lecture
Lecture sponsored by State Volunteer Mutual Insurance Company

2:15 p.m.
Second Socio-economic Session
Speaker to be announced

3:30 p.m.
Afternoon Break
3rd Exhibit Time
Grand Prize for AMS members sponsored by Tours & Travel of Russellville

6:30 p.m.
Western Hoedown
Entertainment: KSSN Bandits - Dress is Casual
Sponsored by Freemyer Collection System and American Health Care Providers, Inc.

Saturday, April 17, 1993

7:30 a.m. - 11:00 a.m.
Registration

7:30 a.m.
Council Meeting

8:00 a.m.
Early Morning Refreshments

8:45 a.m.
"Universal Health Care - The Minnesota Plan"
The Honorable Paul Anders Ogren
Minnesota State Representative
President, State Alliance for Universal Health Care
Saint Paul, Minnesota

10:30 a.m.
House of Delegates

11:30 a.m.
Fifty Year Club Luncheon

12:30 p.m.
Open for Derby Day at Oaklawn, shopping or other recreational activities. Specialties can elect to meet.

7:30 p.m.
Inaugural Banquet

9:00 p.m.
President's Reception

69th Auxiliary Annual Session Program

Arlington Hotel Hot Springs, Arkansas
April 15 - 17, 1993

Thursday, April 15, 1993

1:00 p.m. - 5:00 p.m.
Registration

2:00 p.m.
Pre-Convention Board Meeting

4:00 p.m. - 5:00 p.m.
Welcome Reception
1st Exhibit Time
Sponsored by Worthen National Bank of Arkansas

6:30 p.m.
Blue Cross Blue Shield Reception
By the Pool Deck - Dress is Casual

Friday, April 16, 1993

7:30 a.m. - 4:30 p.m.
Registration

8:00 a.m.
Continental Breakfast
2nd Exhibit Time

Past President's Breakfast

9:00 a.m.
Opening General Session
Sandy Harrison, President, presiding
General Business, Roll Call and Seating of Delegates
Mrs. Barbara Tippins, Field Director
American Medical Association Auxiliary
Mrs. Mildred Taylor, President-elect
Southern Medical Association Auxiliary
J. Larry Lawson, M.D., President
Arkansas Medical Society
Mr. Ken LaMastus, Executive Vice President
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Ms. Kay Waldo, Director of Administrative Services
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Mrs. Barbara Tippins
Convention Announcements
Kay Borg and Laura Larrison, Convention Chairmen
Reports of Officers and Committee Chairmen
Unfinished Business
New Business
Election of the Nominating Committee for 1993-1994
(2 from the Board; 2 from the House of Delegates)
Election of Delegates and Alternates to the 1993
AMA Auxiliary Convention, Chicago
Presentation of the 1993-1994 Budget
Mrs. Sandra Lyons, Finance Chairman

12:30 p.m.
Shuffield Luncheon/Lecture
Lecture sponsored by State Volunteer Mutual
Insurance Company

2:30 p.m.
Reconvene General Session

6:30 p.m.
Western Hoedown
Entertainment: KSSN Bandits - Dress is Casual
Sponsored by Freemyer Collection System and
American Health Care Providers, Inc.

Saturday, April 17, 1993

7:30 a.m. - 10:00 a.m.
Registration

8:30 a.m.
Second General Session
Mrs. Sandy Harrison, President, presiding
General Business
Greetings from Southern
Mrs. Mildred Taylor
Reports by County Presidents
Moderators: District Vice Presidents
Unfinished Business
New Business
Nominating Committee Report
Mrs. Rita Rodgers
Election of Officers
Adjournment

10:00 a.m.
AMSA Installation Brunch
Mrs. Sandy Harrison, President, presiding
Presentation of Awards
Installation of Officers
Mrs. Barbara Tippins
Adjournment
Afternoon is open for Derby Day or other recreation.

7:30 p.m.
AMS Inaugural Banquet

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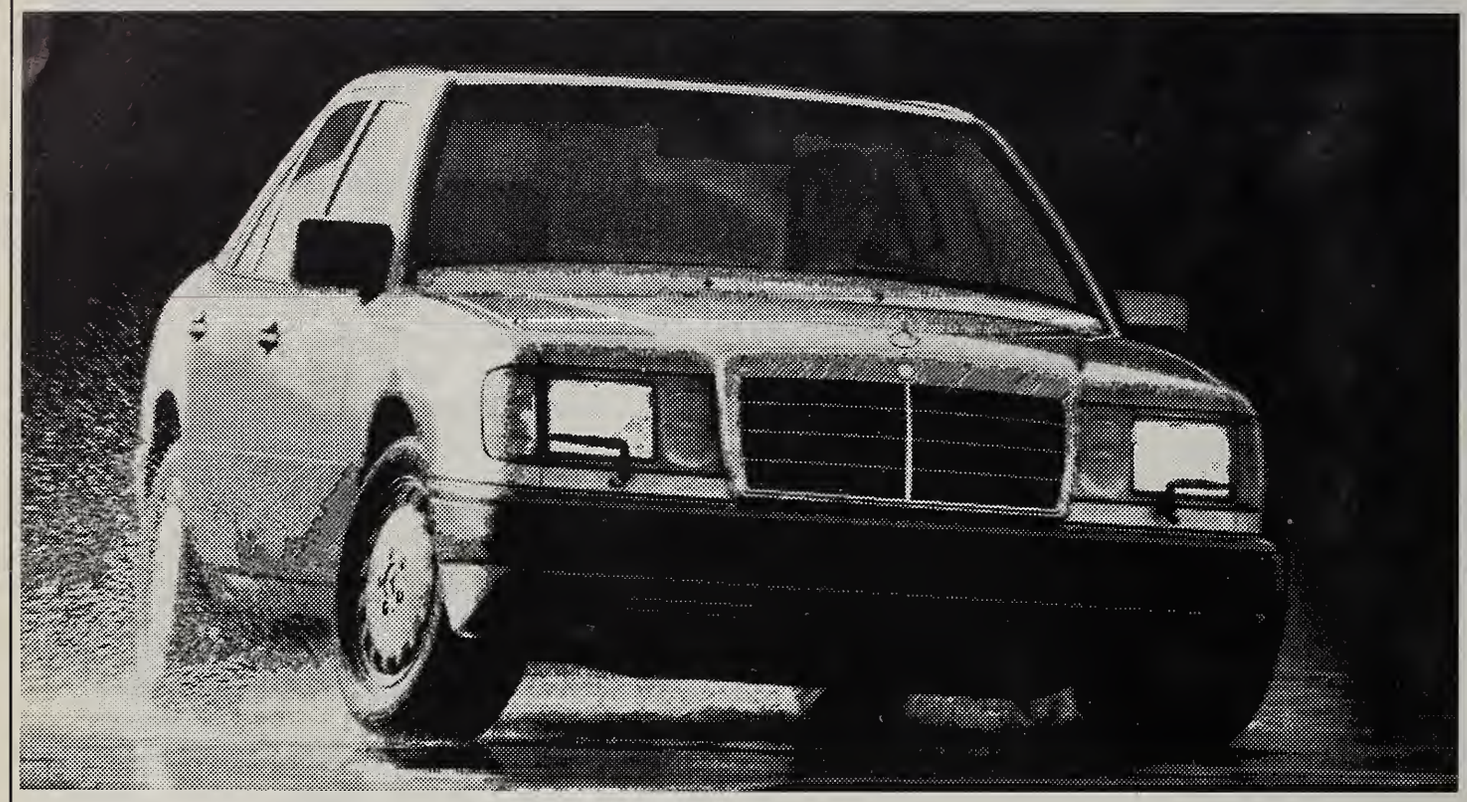

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The Reemergence of Tuberculosis in Arkansas

Rachel M. Butler*

HISTORY

In 1815, "Consumption" was said to have been the cause of premature death in 1/4 of all of the inhabitants in Europe, and was so fatal as to deter the physician from even attempting a cure. From health records in Philadelphia, Boston, and New York in 1850, it is estimated that the tuberculosis death rate in the United States was about 400 per 100,000 population.[1] In 1882, Robert Koch discovered the tubercle bacillus and in 1886 the first tuberculosis sanatorium was founded.

In 1908, tuberculosis, "the White Plague", killed 3,000 people in Arkansas. It was the number one cause of death in the state. In 1909, Act 378 created the Arkansas Tuberculosis Sanatorium, to treat the citizens of Arkansas suffering from TB. It officially opened with 15 patients. The patient number continued to increase until in the 1940s, during and after the War, it reached its maximum census of more than 1,100 patients. With the introduction of the anti-tuberculosis drugs, great changes were made in the treatment procedures. The inpatient population began to decline in the 1950s and in 1973, the seven remaining patients were discharged. The Arkansas State Health Department became responsible for treatment of tuberculosis patients. Currently, treatment is administered through county health clinics, regional hospitals and some private hospitals.

In 1969, the U.S. Surgeon General testified to Congress that it was time to "close the book on infectious diseases." In fact, infectious diseases have not been eradicated but remain the largest cause of death in the world today, greater than cardiovascular disease or cancer.[2]

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ETIOLOGY

Tuberculosis is a communicable disease caused by bacteria. The primary etiologic agent is *Mycobacterium tuberculosis*. It is a slow growing, aerobic, non-spore forming bacillus. Characteristically, culture growth requires approximately three to six weeks of incubation. However, a new radiometric system may yield results in two to six days.[3]

During the initial (primary infection) of immunocompetent persons with *Mycobacterium tuberculosis*, macrophages ingest the organisms and process and present mycobacterial antigens to T-cells. CD4 cells secrete lymphokines that enhance the capacity of macrophages to ingest and kill mycobacteria. In most people, tuberculosis infection is contained and tuberculosis does not develop, although small numbers of dormant bacilli may remain in the body. Clinically apparent tuberculosis develops in approximately 10 percent of infected patients, soon after primary infection or years later (reactivation tuberculosis). These consequences are thought to be due to defects in T-cell or macrophage function, or both.[4]

TRANSMISSION

Mycobacterium tuberculosis is carried in airborne particles, known as droplet nuclei, that can be generated when persons with pulmonary or laryngeal tuberculosis sneeze, cough, speak, or sing. The particles are so small (1.5 microns) that normal air currents keep them airborne and can spread them throughout a room or building. Infection occurs when a susceptible person inhales droplet nuclei containing *M. tuberculosis*, and bacilli become established in the alveoli of the lungs and spread throughout the body. Two to ten weeks after initial human infection with *M. Tuberculosis*, the immune response usually limits further multiplication and spread of the tuberculosis bacilli. For a small proportion of newly infected persons (<1%), initial infec-

tion rapidly progresses to clinical illness. However, for another group (approximately 5%-10%), illness develops after an interval of months, years, even decades, when the bacteria begin to replicate and produce disease. The progression to active disease is markedly increased for persons with HIV infection.[5]

The probability that a susceptible person will become infected depends upon the concentration of infectious droplet nuclei in the air. Environmental factors that enhance transmission include a) contact between susceptible persons and another infectious patient in relatively small, enclosed spaces, b) inadequate ventilation results in insufficient dilution or removal of infectious droplet nuclei, and c) recirculation of air containing infectious droplet nuclei.[5]

Tuberculosis transmission is a recognized risk for health care workers, in health care settings. The magnitude of risk varies considerably by type of health care setting, patient population served, job category, and the area of the facility in which a person works. The risk may be higher in areas where patients with tuberculosis are provided room before diagnosis (e.g., clinic waiting areas and emergency rooms) or where diagnostic or treatment procedures that stimulate patient coughing are performed.[10] Nosocomial transmission of tuberculosis has been associated with close contact to infectious patients, as well as procedures such as bronchioscopy, endotracheal intubation and suctioning with mechanical ventilation, open abcess intubation, and autopsy. Sputum induction and aerosol treatments that induce cough may also increase the potential for tuberculosis transmission. Health-care workers should be particularly alert to the need for preventing tuberculosis transmission in health care settings in which persons with HIV infection receive care, especially if cough-inducing procedures such as sputum induction or AP treatment are being performed.[4]

DIAGNOSIS AND TREATMENT

In early stages, *Mycobacterium tuberculosis* infection can be only detected by a "Tuberculin Skin Test". Lab tests are then performed including: a sputum smear, a culture test, further testing to determine "atypical tuberculosis", common in patients with HIV, and sensitivity tests to test for drug-resistance.

Isoniazid (INH) was introduced in 1952 and is still one of the most effective medicines against TB. Rifampin (RIF), the newest TB medicine, was introduced in 1971. When combined with INH it is effective in completing treatment in 9 months. These antibiotics, along with several others now available, have a 95% cure rate, when taken properly. Today, the problem lies with new strains of drug-resistant *M. tuberculosis* that have emerged in large cities, on the Mexican border and areas with refugees from Asia, Africa and South and Central America, along with "atypical" tuberculosis in HIV infected persons.[6]

Pulmonary involvement occurs in 74 to 100 percent of patients with HIV infection and tuberculosis. The diagnosis of tuberculosis may permit early identification of HIV infection, the institution of anti-retroviral therapy, and counseling to reduce the transmission of the virus. Outbreaks of tuberculosis stemming from HIV-infected source patients have been reported, and the transmission of drug-resistant organisms has resulted in substantial morbidity and mortality. A recent report finds that tuberculosis developed in 44 percent of inpatients with HIV infection after exposure to a source case.[7]

POPULATION AT RISK

Tuberculosis is not evenly distributed throughout all segments of the population of the United States. Groups known to have a high incidence of tuberculosis include Blacks, Asians, Pacific Islanders, American Indians, Alaskan Natives, Hispanics, current or past prison inmates, alcoholics, IV drug users, the elderly, foreign-born persons from areas of the world with a high prevalence of tuberculosis (e.g., Asia, Africa, the Caribbean and Latin America), and persons living in the household with members of these groups.

Viable bacilli will survive and cause a positive tuberculin skin test if conditions permit, e.g., patient is in failing health, has Type I Diabetes Mellitus, has prolonged corticosteroid therapy, or other impairment of the immune system. As a result, in the U.S. the tuberculosis case rate among persons over the age of 65 is higher than in any segment of the population, save for persons with HIV infection. Case rates are much higher for residents of nursing homes than for the elderly population in general. About 90% of the disease infection in the elderly results from the late progression of infection acquired in earlier years.[6]

HIV AND TUBERCULOSIS

Ongoing analyses of tuberculosis morbidity data continue to identify the magnitude and extent of the problem. These data have important implications for the control and elimination of tuberculosis in the United States.

From 1953 through 1984, the number of tuberculosis cases reported decreased an average of 5% annually. However, in 1983, the number of tuberculosis cases remained stable and, in 1986, cases increased by 2.6%. This increase was, in part, caused by the occurrence of tuberculosis among persons infected with HIV. HIV infection appears to have increased the incidence of tuberculosis by causing immunosuppression, which allows latent tuberculosis infection to progress to clinically apparent disease.[9]

It is estimated that 10 million persons in the United States are infected with *Mycobacterium tuberculosis*, and

1 million persons are infected with HIV. The magnitude of future problems depends on the extent of overlap between these two populations.[4]

Tuberculosis usually occurs in HIV-infected patients without preexisting AIDS, presumably because *M. tuberculosis* is more virulent than other HIV-associated pathogens. Tuberculosis is therefore more likely to cause disease at an earlier stage of immunodeficiency.[4]

HIV is characterized by progressive depletion and dysfunction of CD4 cells, as well as defects in macrophage and monocyte function. Because CD4 cells and macrophages have a central role in anti-mycobacterial defenses, dysfunction of these cells places patients with HIV infection at high risk for primary or reactivation tuberculosis. Epidemiologic evidence indicates that HIV infection increases the risk of reactivation of latent tuberculosis infection,[4] and increases the risk of progressive diseases from new infection.[7] Figure A shows the estimated cases of TB in the U.S. from 1978 to 1991.

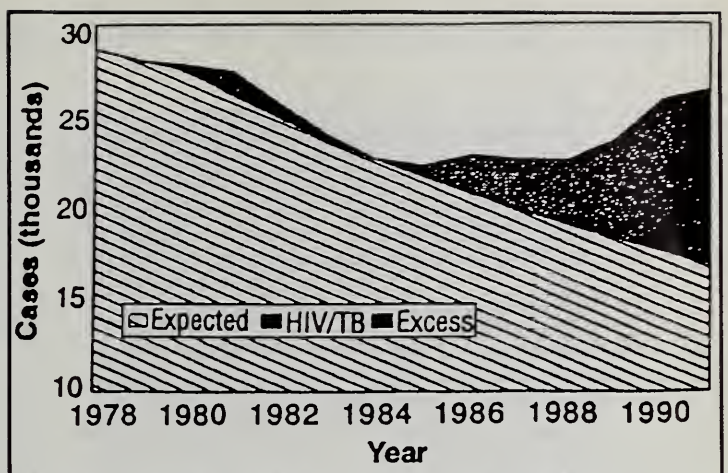

Figure A. Estimated cases of TB in the United States from 1978 to 1991, disaggregated into cases expected on the basis of trends in the risk of infection, cases of HIV and TB co-infection, and excess cases.[2]

risk of infection, except for those few cases that are a result of HIV infection in infants and children.[2]

THE FACTS

ARKANSAS	U.S.
1950s	**1950s**
- 1,598 cases of TB, 88% in advanced stage.	- Case rate: 60/100,00
- Death rate: 16/100,000	- Death rate: 10/100,000
- Rate of occurrence decreasing only 3% per year.	- Rate of occurrence decreasing decreasing at 9% per year.
- Increase of TB in non-white males and persons age 64 and over.	
- Lowest nurse per capita ratio of any state in the nation.	
1970s	**1970s**
- Case rate: 25.8/100,000 (7th highest in U.S.)	- Case rate: 18.3/100,000
1990s	**1990s**
- Case rate: 9.9/100,000 (age 20-64)	- Total cases increase 18% (since 1985)
- Case rate: 50.8/100,000 (age 65+)	- 14.0% lived below poverty level
- 22.9% lived below poverty level	

(Sources: 6, 8, 9, 10, 11, 12)

From 1983-1991, nationwide, there were 1 million reported cases of HIV, a case rate of 17/100,000; 18,000 resulted from co-infection (HIV and TB). Arkansas ranked 22nd in the U.S., with 1,282 cases, a case rate of 8.7/100,000; the number of co-infection cases is unclear.[3]

The number of cases of TB in U.S. children age 5 and under has increased 34% from 1987-1990. Because all of these infections must have occurred in the last 5 years, this implies an increase of more than 10% per year in the

FUTURE

Five possible factors could explain the reversal of the nearly century-long decline in the annual risk of infection: i) the HIV epidemic; ii) an increasing homeless population with high potential for transmission and breakdown through adverse living conditions; iii) increasing numbers of IV drug users with similar living conditions; iv) the concentration of all three of these risk factors in the same individuals or population subgroups, such that those at high risk for breakdown are at a high risk for transmission, and v) at a time when the needs for TB control have increased, many city and state governments have been unable to maintain or improve their TB treatment programs.[2]

The direct treatment costs of the excess cases since 1985 that were a result of increased active transmission equal $340 million. To this the human suffering is quantified as 4,400 discounted years of healthy life and the human suffering costs of lost productivity $300 million.[2]

In the United States a generation of expertise has been lost. NIH-support for research dwindled in the 1970s and, though now rising, is inadequate to address the scientific challenges of TB.

Predicting the future of TB is difficult. Case numbers resulting solely from increased HIV infection will remain roughly 4,000 to 5,000 new cases per year, over

TABLE 1. Improving Methods for Prevention, Diagnostic, and Treatment Technologies (Summary Sheet)

Kind of research	I. Preventing disease in infected persons	II. Identifying infected persons at risk of disease	III. Treating disease	IV. Preventing infection	V. Diagnoses of disease
Basic	1. Identify target sites of drug action; develop new therapeutic approaches. 2. Develop models to assess interaction of drug, host, and organism. 3. Develop animal models for preventive therapy. 4. Study mechanisms of INH-hepatitis. 5. Develop postinfection vaccines to boost immunity. 6. Boost host immunity to destroy intracellular bacilli.	1. Study differences in T-cell memory between infected persons who do or do not develop active disease. 2. Look for genetic differences between infected persons who do or do not develop disease. 3. Characterize genes that code for specific epitopes of mycobacteria.	1. Define target enzymes for anti-TB drugs; design new drugs or modify existing ones with higher affinity for target sites. 2. Improve knowledge of drug transport mechanisms so drugs can be developed/ modified to facilitate uptake into intracellular environment of macrophages. 3. Identify pharmacologic agents that activate T-cells/macrophages. 4. Enhance microbicidal activity of *in vitro*-maintained phagocytes by manipulation of micro-environments.	1. Pursue studies on tubercle bacilli relevant to infectivity and pathogenicity. 2. Compare uptake, micro-environmental distribution, and replication of avirulent, attenuated, and virulent tubercle bacilli. 3. Determine host factors (HLA phenotype) that affect susceptibility and resistance to TB infection. 4. Develop nonliving, non-allergenic vaccine to prevent establishment of infection. This research should include efforts to (a) identify epitopes of *M. tuberculosis* responsible for protection and produce same by genetic engineering; (b) maximize protection by different immunization methods or regimens; (c) develop bio-logic response modifiers to enhance protection; and (d) identify populations in which vaccine could be tested.	1. Search for genus- and species-specific epitopes. 2. Develop assays for diagnostic materials produced by lymphocytes or macrophages of diseased host; also investigate T-lymphocyte antigen receptor.
Applied	1. Develop animal model to evaluate different single or combination drugs for preventive therapy. 2. Develop bactericidal INH congeners that are not hepatotoxic. 3. Develop cytoprotective agents to neutralize INH toxicity. 4. Develop long-acting depot forms of anti-TB drugs. 5. Develop and evaluate postinfection vaccines for TB.		1. Evaluate antimyco-bacterial activity of all new antimicrobials, and test combinations for synergy. 2. Seek bactericidal agents that affect myco-bacteria in all metabolic states. 3. Study pharmacologic agents that activate T-cells and macrophages. 4. Investigate techniques that enhance microbicidal activity of phagocytes. 5. Investigate improved drug-delivery systems.	1. Define better methods for air disinfection. 2. Evaluate new vaccines shown in experimental models to prevent infection.	1. Evaluate DNA probes specific for *M. tuberculosis*. 2. Produce and evaluate genus- and species-specific monoclonal antibodies for rapid identification of *M. tuberculosis*. 3. Use probes or mono-clonal antibodies to detect, in clinical specimens, either intact mycobacteria or their antigens that would be diagnostic of disease.
Epidemio-logic/Oper-ational	1. Compare alternative to daily INH preventive therapy. 2. Determine risk factors that precipitate INH-hepatitis. 3. Identify "risk factors" to measure benefits of preventive therapy.	1. Assess risk of tuberculosis among those infected with both *M. tuberculosis* and HIV. 2. Conduct prospective studies to investigate risk factors for active disease, e.g., socio-economic status, weight, nutrition, environment.	1. Investigate B-lactams, long-acting sulfones and sulfonamides, rifamycins, and 4-quinolones. 2. Identify compliance enhancers or incentives and develop tests to recognize people who best respond to them.	1. Define methods that identify groups or individuals at risk of infection. 2. Examine patient characteristics that influence infectiousness.	1. Evaluate diagnostic methods under field conditions.

the next decade. In a worst case scenario, total TB cases might continue to rise at the same rate as in the period of 1985 to 1991. This would mean costs would total $2.2 billion, and that indirect costs would total $1.9 billion.[2]

The United States spends 12% of its gross national product on health care, though it is unclear exactly how much is spent to prevent disease rather than treat it. We know how to cure and prevent conventional TB; we must quickly develop the capacity to prevent the spread of drug-resistant TB. If we do not learn from the current epidemic of TB and if we do not develop new scientific tools to diagnose, prevent, and treat the disease, the tragedy unfolding in urban cities now could be repeated in any city in America that has homeless people, AIDS, prisons, hospitals and nursing homes.[2,12]

CONCLUSION

In the state of Arkansas, factors such as the overcrowding in prisons, the large percentage of the elderly in the state; unfavorable socio-economic conditions; the large minority population afflicted, for example, TB rates are 62/1,000 for whites vs. 114/1,000 for blacks in Arkansas prisons; and the number of HIV infected persons all contribute to the slow decline of the total tuberculosis case rates prior to 1985, then the sharp increase from 1985-1991. There has been no increase in health care budget for the Arkansas Tuberculosis Program since the 1970s. It is this writer's opinion, that there needs to be an increased number of local health care offices (there are currently only 9 in the state); better preventive measures in nursing homes; and because of the likelihood of nosocomial infection, there should be across the board testing for all entering hospital patients; and physicians and health care workers need to be trained to have a high degree of suspicion of TB when working with HIV patients. Table 1 is the MMWR Summary of Methods for Prevention, Diagnostic and Treatment Technologies, 1989. The writer feels that these national recommendations should be closely noted and observed in the state of Arkansas.

REFERENCES

1. Pfeutze KH, Stocklen JB. A Report on Tuberculosis Control in Arkansas. Ark. Tuberculosis Assoc. Little Rock. 1967.
2. Bloom BR, Murray C. Tuberculosis: Commentary on a Reemergent Killer. Science 1992; 257: 1055-61.
3. Fournier DC. Tuberculosis and HIV in AIDS in Arkansas. J. Ark. Med. Soc. 1991; 87: 369-71
4. Barnes PF, Bloch A, Davidson P, Snider D. Tuberculosis in Patients with Human Immunodeficiency Virus Infection. The N. Engl. J. of Med. 1991; 324 (23): 1644-49.
5. MMWR. 1990. Rep. 39, No. 22.
6. Stead WW, Dott AK. Tuberculosis in Elderly Persons in Arkansas. Annu. Rev. Med. 1991; 42: 267-76.
7. Selwyn PA, Hartel D, Lewis VA, et al. A Prospective Study of the Risk of Tuberculosis Among Intravenous Drug Users with Human Immunodeficiency Virus Infection. N. Engl. J. Med. 1989; 320: 545-50.
8. MMWR. 1990. Rep. 39, No. RR-77.
9. MMWR. 1989. Rep. 38, No. S-3.
10. Summary of Arkansas Tuberculosis Statistics, Arkansas Tuberculosis Foundation, 1974.
11. U.S. Dept. of Health and Human Services. DHS, CDC, Atlanta. 1990.
12. Di Perri G, Cruciani M, Danzi MC, et. al. Nosocomial Epidemic of Active Tuberculosis Among HIV-Infected Patients. Lancet. 1989; 2: 1502-4.
13. MMWR. 1990. Rep.40, No. SS-3.
14. MMWR. 1991. Rep. 40, No. 34.

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Patient Allegedly Abandoned by Physicians and Hospital

Cindy Conkle, RN, BA, ARM*

Does the physician have a duty to see every patient? Or can a physician be selective in the type of patients he or she sees? Must a physician always do what the patient demands? How can physicians terminate relationships with non-compliant patients? When can a physician terminate a relationship with a patient?

These questions are frequently asked of risk management professionals and health care attorneys. The following case provides some insight into these issues.

Case History

A 20-year-old black female college student was admitted at 6 p.m. through the Emergency Department (ED) with the diagnosis "sickle cell crisis". The patient's family physician was also "on-call" for the ED. He had seen the patient many times before. However, because he had the flu he transferred the care of the patient to an internist. The internist also had seen the patient before for other episodes of sickle cell crisis.

Admission hemoglobin was 7.2, WBC 22,600, electrolytes normal, reticulocyte count 0.1%, positive sickle cell prep and electrophoresis showed sickle cell hemoglobin. The patient complained of pain in the legs and back. Lungs were clear and heart rate was regular sinus rhythm. The ED physician talked with the internist who had accepted the care of the patient from the primary physician. The internist did not come in to see the patient but left admission orders:

Diet as tolerated
Percodan and Tylenol for pain
Demerol and Phenergan for pain
Vistaril for anxiety
IV TKO (to keep open)
O_2 3 liters

The patient's vital signs prior to being transferred to a regular medical-surgical bed were: blood pressure 110/70, temperature 36.2°C, pulse 92 and respirations 44.

The internist did not see the patient for this acute illness until the next morning.

During the night, the patient began chilling and was short of breath. Her temperature was 36.7°C. She continued to complain of pain in her back, chest and upper legs. While the patient was assisted to the bathroom, the nurse noted an "unsteady gait". She voided once during the night, a small amount of very dark amber urine. No intake and output records were kept. Later in the night she became restless, complaining of pain in her lower back and legs. She was also moaning, grunting and crying.

Around 9 a.m. the next morning, a urine sample obtained revealed a specific gravity of 1.011. Morning blood work revealed reticulocytes 0.1 percent, hemoglobin 6.6 and pematocrit 20.7.

The internist came in to the hospital to see the patient and talked with the patient's mother. The mother expressed her concern that her daughter was receiving too much medication because she was sleeping and extremely relaxed.

The only nurses' notes for the day shift, written at 2 p.m. by an LPN, said, "O_2 on occasionally. Diet taken poor. Mouth care. Bed bath by mother. Up in chair. Vital signs OK except for slight temperature elevation. K-pad to back. Complains of leg and back pain."

During the evening, the patient was assisted to the bathroom two times; each time she voided a small amount of very dark amber urine. She had received approximately 1500 cc of fluids during her first 24 hours in the hospital. By 10 p.m. she was "feeling a little better."

Just two hours after she was "feeling a little better", she became very anxious and began moaning, crying and calling out. She complained of a headache and back

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pain. She continued to be very restless, trying to get out of bed over the side rails. While up, the nurse noted that she had a "shuffling gait". By 2:30 a.m. the nurses' notes read, "lies in a daze".

At 7 a.m. the patient was restless, again trying to get out of bed. She was helped to the bathroom and voided a very small amount of dark amber urine. Hemoglobin was 5.8.

Shortly thereafter, the internist visited the patient and discussed her treatment with the mother and father. The internist wanted the patient to undergo a bone marrow aspiration for definitive diagnosis of sickle cell crisis, aplastic anemia. The physician and family got into a dispute and by 8 a.m., the patient and family refused to sign a consent for the bone marrow aspiration.

At 8:40 a.m., the internist signed off the care of the patient on the medical record. He wrote in his progress notes, "the family is aware they are to call the primary care physician." The nursing supervisor was notified, but didn't make any chart notations. She also did not notify anyone.

By 10 a.m. the patient's condition continued to deteriorate. The mother complained that her daughter was sleeping frequently and was difficult to arouse. Upon waking, she would immediately doze off. Around 11 a.m. the nurses notified the primary care physician who was still ill and could not come in. During a telephone conversation, he instructed the nurse to "call the internist and see who should see the patient." Again, the nursing supervisor was notified.

The internist felt it was the family's responsibility to find a new physician. The family felt it was the hospital's responsibility to find a new physician. The nursing supervisor considered it the physician's responsibility to find a new physician. Consequently, the patient's condition continued to deteriorate with no physician assuming medical care responsibilities.

There is no notation on the medical record as to who was called to take over the medical care of the patient or when those calls were made. However, at 2 p.m. a general practice physician called the charge and agreed to take over the care of the patient. No report was given to the general practice physician about the patient's condition from the nurses or internist.

The patient continued to be restless, complained of pain and had little output. At 5:15 p.m. the general practice physician came in to see the patient, who was "semi-comatose". She would open her eyes when spoken to but would not answer any questions. At 7:30 p.m. the general practice physician called in a specialist to consult on the case.

It wasn't until 10 p.m. that the nursing staff became notably concerned about the patient's condition and called the general practice physician. The patient's blood pressure was 100/74, pulse 152, respirations 40. The temperature remained at 37°C. The patient hadn't voided for the entire shift, was comatose and "bleeding from all parts of her body". the physician ordered a stat H & H and increased the IV rate to 100cc per hour. At this time the hemoglobin was 4.4 and the hematocrit was 12.8.

By 11:30 p.m. the general practice physician again came to see the patient, contacted the consultant and transferred her to ICU. The patient moaned with movement, didn't open her eyes and only grimaced with pain. By 1 a.m. the next morning her condition was being treated rigorously with oxygen, blood transfusions and IV fluids. The patient continued to deteriorate, however, and by 3 a.m. had a palpable blood pressure of 76.

The patient's outcome? The patient's CT and EEG showed diffuse ischemic insult. She had renal failure and was on dialysis.

Expert Review*

The primary care physician, internist, general practice physician, consultant and the hospital were all sued in this case.

Who was responsible for the care of the patient, the primary physician who was sick at home, the internist who signed off the case, the general practice physician, the consultant or the hospital?

The primary care physician was dismissed from the lawsuit - he never saw the patient, nor did he assume her - as it was believed he had no duty to the patient.

The experts who reviewed this case felt the internist was responsible for the stabilization and treatment of the acute illness until a qualified substitute was willing to take over the case. Expert testimony raised concern that the general practice physician was not experienced in effectively treating sickle cell crisis.

They also thought the hospital was responsible for ensuring that appropriate medical care was provided to the patient.

The experts' opinion was that the general practice physician and consultant were responsible for care and treatment once they agreed to take the patient.

At what time did the patient's condition deteriorate so badly that she became unsalvageable, before or after the general practice physician accepted care? Was the delay in obtaining another physician the proximate cause of the patient's outcome?

Experts who reviewed this case felt that when the internist removed himself from the case the patient was in renal or pre-renal failure. They felt that hydration, transfusion, analgesic and antibiotic therapy could have been given without a definitive diagnosis and, that the bone marrow aspiration was unnecessary. They also felt

* *The information provided reflects the collective opinions of experts who were presented by the plaintiff and defendant.*

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that if hydration and transfusions were given within the first 24 hours of admission, no neurological or renal damage would have occurred. The experts all agreed that the patient was salvageable on the day she had no physician until around 5 p.m. with aggressive therapy. There were many other difficulties in this case. Documentation by the physicians and nursing staff was sketchy, with only end-of-shift summary nursing documentation. The charge nurse worked at the nursing desk and did not receive patient reports nor did she see any of the patients. There were no written protocols to follow when a physician signed off the case.

The experts reviewing this case felt that a number of problems existed in this scenario. The internist should have handled the crisis or acute illness prior to signing off and discussed the patient's condition with the general practice physician. In addition, they felt that he should have treated the aplastic crisis, hydrated the patient and seen the patient after admission to the hospital instead of waiting until the next morning.

The experts maintained that the hospital's communication, documentation and organization was poor. The charge nurse did most of the charting, yet never saw the patient. The LPN responsible for the patient's care did not report information to the nursing team leader who gave the end-of-shift report. Even though they recognized the patient was dehydrated, the nurses failed to personally inform the physician. They failed to initiate intake and output readings to assess hydration and did not recognize the seriousness of the patient's condition and notify the physician. The nurses failed to follow the chain of command or follow-up once the physician signed off the case. The nursing supervisor failed to follow the chain of command to obtain appropriate medical care, and, finally, from 8 a.m. until 2 p.m. when there was no physician on the case, no registered nurse saw or assessed the patient.

The experts also noted that the general practice physician did not recognize the urgency of the patient's condition. He should have responded sooner, an indication that he did not understand the nuances of sickle cell disease.

Risk Management Tips

In this case, the experts felt that the hospital had a duty to monitor the patient and provide appropriate medical care. The following risk management tips may help avoid similar claims:

✓ Educate nursing and medical staffs on the chain-of-command.
✓ Implement a policy or procedure on steps to take when a physician wants to sign off a case.
✓ Assess the patient, at least once per shift by a registered nurse.
✓ Examine the type of nurse staffing used and the communication required. Each type of staffing, such as team nursing, functional nursing, primary care nursing or a combination, requires different communication processes. In this case, team nursing was used. The team leader never saw the patient, yet was the person responsible for the end-of-shift report. The charge nurse never saw the patient as she was responsible for noting orders and charting. The charge nurse assumed the team leader was aware of the patient's condition and the team leader assumed the charge nurse was following up on the patient. The LPN taking care of the patient would report the patient's condition to the RN easiest to find. There was no systematic way of communicating the patient's condition or progress.
✓ Document assessment findings, observations, conditions, treatments and response to treatments in a systematic logical fashion.
✓ Make sure that the physician assuming the care of a patient for another physician is skilled and knowledgeable in the disease/condition involved.
✓ Follow established protocols for nursing interventions.

As for physicians, there may be times when transferring the care of a patient to another physician or terminating the physician-patient relationship is necessary. This may occur because the patient is non-compliant or misses appointments. It may be because the physician is retiring or leaving the area. Another reason

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a physician may sign off a case is because the patient or patient's family wants another physician. In this case, the initial sign off resulted from the physician's illness; the internist withdrew from the case following a disagreement with the family and patient.

If a physician needs to terminate the relationship with the patient, he or she must do so very carefully to prevent abandonment claims. Each state may have legal requirements for terminating physician-patient relationships. These should be reviewed prior to taking any actions. In addition, physicians may want to follow these general guidelines:

✓ Medical care to the emergency or acutely ill patient should be continued. A physician who has accepted the care of a patient in an acute state should continue to care for that patient until the condition is stabilized or cured. If for some reason the family does not want the physician, the physician may still be held responsible for the care and treatment of that patient until another physician is willing to take over that care.

✓ For hospitalized patients, it is dangerous for physicians to terminate the relationship. The treating physician may be held responsible for the patient's care until a competent physician substitute has assumed full management of the patient's case.

✓ Provide notice to the patient, preferably in writing, that continuation of the physician-patient relationship is impossible and the reasons why. Include the date when you will no longer care for the patient. The language should be appropriate for the patient's level of understanding. This should be hand delivered or mailed by return receipt mail.

✓ Give the patient ample time to obtain another physician.

✓ Assist the patient in finding another physician by referring him or her to the state or county medical societies or local hospital or referral center.

✓ Offer to transfer the medical records to the new physician. This should be done only after proper authorization is signed.

✓ Communicate the roles of each physician - those transferring care and those accepting care - to help avoid confusion or misunderstanding.

Conclusion

The patient is now bed-ridden, living with her parents, who provide activities of daily care. Her mental condition is at a pre-kindergarten level.

Each physician settled for their policy limits. Had the case been tried to completion, the potential jury verdict was estimated at $3-$7 million. The hospital settled for $1.5 million.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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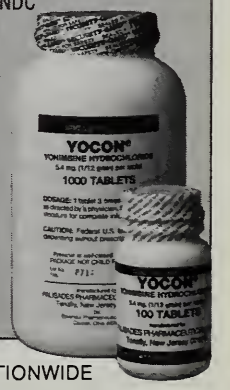

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Medical Qualification of Sport Scuba Divers

J. William Kinsinger, M.D.*
Johnny E. Brian, Jr., M.D.**

INTRODUCTION

Recreational scuba diving is a popular sport in Arkansas, a state blessed with abundant and beautiful lakes and streams. Scuba diving involves some unique physiologic considerations, and an understanding of this physiology is important in assessing the impact of disease processes on the ability to dive. As our populations ages, so does the population of individuals who desire to be or are involved with recreational scuba diving. Thus the likelihood of associated medical or surgical conditions in this population is increasing. Medical qualification of these individuals for participation in recreational scuba diving is a question which may face physicians with increasing frequency. Some physicians would disqualify any individual with any medical or surgical condition. However, this is an unnecessarily restrictive approach and would prevent some individuals from pursuit of a recreation of their choice. More rational decisions can be arrived at with an understanding of the considerations involved. Common questions involve disease processes of the cardiovascular, respiratory, neurologic, otorhinologic systems. We will attempt to provide some insight into how disease processes in these systems may impact one's ability to dive, and some conditions that should be considered contraindications to scuba diving.

Some individuals would argue that any increased medical risk incurred in diving is assumed by the individual involved, and individuals should be free to decide based on the information available. However, this is not the case as there may be risks to other divers and non-divers who might be involved in rescue of an individual who suffered medical decompensation during diving.

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CARDIOVASCULAR SYSTEM

Diving places increased demands on the cardiovascular system due to a variety of factors including exertion, stress and cold water, all of which increase circulating catecholamines, blood pressure and myocardial oxygen consumption. Additionally, total body immersion increases the afterload which the heart must work against.

Hypertension

Adequate control of hypertension is important in the diving candidate as sudden, acute elevations in blood pressure as occur with the demands of diving can lead to stroke or myocardial ischemia, either of which would produce catastrophic consequences while underwater. In evaluating a hypertensive candidate for fitness to dive, evidence of end organ disease should be sought. Patients that control their blood pressure by weight loss, diet, exercise, and diuretics and who have normal end organ function can be cleared for diving. Because of the potential need to increase cardiac output during diving, patients taking beta blockers or any drug that depresses the autonomic nervous system function should be subjected to an exercise electrocardiogram. Minimum acceptable requirement for diving has been suggested to be 14 METS.

Coronary Artery Disease & Myocardial Infarction

All diving candidates should be made aware of the major risk factors for coronary artery disease and encouraged to reduce those which can be altered. Because acute myocardial infarction is the most common initial presentation of coronary artery disease, the consequences can be catastrophic while diving. One suggestion for evaluating the cardiovascular system of diving candidates over 40 years of age and any who are poorly conditioned or who have multiple risk factors for coronary artery disease is to undergo an exercise electrocardiogram. In order to be cleared, 14 METS should be achieved. In case of an abnormal test, exercise scintigraphy or cardiac catheterization can be performed

with a cardiologist's evaluation and recommendation before a candidate cleared to dive.

Patients who have recovered without sequelae from an myocardial infarction, undergone coronary angioplasty or bypass grafting and undergone lifestyle changes to reduce their risk factors could, on an individual basis, be considered for clearance. This should be done in concert with the patient's cardiologist and following a thorough evaluation including cardiac catheterization. However, a more conservative approach in patients with angina, a history of myocardial infarction or of arrhythmia due to coronary artery disease is to exclude them from participating in diving.

Electrocardiographic Abnormalities

Third degree block or Mobitz Type II block are absolute contraindications to diving as they can prevent adequate cardiac response to stress. First degree block and Mobitz Type I are not disqualifying if the remainder of a thorough cardiac evaluation is normal. Because left bundle branch block is associated with coronary artery disease, a patient with this abnormality should undergo evaluation including exercise thallium scintigraphy or cardiac catheterization prior to clearance. Asymptomatic patients with right bundle branch block can be cleared to dive after successfully completing exercise electrocardiogram to 14 METS. Patients with sinus bradycardia who demonstrate adequate heart rate response to exercise can be approved to dive. Wolf-Parkinson-White syndrome is a contraindication to diving as an episode of sudden tachycardia with unconsciousness underwater could lead to drowning, as can any form of supraventricular tachycardia. Patients with supraventricular tachycardia who are under 35 years of age and who have not had an occurrence of supraventricular tachycardia in greater than 6 months can be cleared to dive as can those patients without a history of syncope and who do not require medication for control of their arrhythmia. Others with supraventricular tachycardia should be subjected to full evaluation before being approved to dive.

Valvular Heart Disease

Any disease that impedes forward flow such as mitral or aortic stenosis is a contraindication to diving. Patients with mild mitral regurgitation who are asymptomatic, have normal left ventricular function, no left ventricular hypertrophy, and minimal left ventricular dilation may be cleared provided the mitral regurgitation is not due to ruptured chordae tendineae or papillary muscle dysfunction. Asymptomatic patients with aortic insufficiency which is hemodynamically insignificant, without left ventricular hypertrophy or dysfunction or only minimal left ventricular dilation can be cleared for diving. Patients with mitral valve prolapse who are not taking medication and are asymptomatic may be cleared for diving.

Congenital Heart Disease

Without exception, any defect which allows communication between the right and left circulations at the level of the heart or great vessels is a disqualification for diving. With lesions as these it is possible that air emboli can cross from the right to the left circulation and thereby to the brain or coronary arteries with resultant obstruction and ischemia. Air bubbles have been documented in the venous circulation following dives that were within recognized safe limits. Patients who have undergone successful repair of non-cyanotic lesions such as atrial septal defect, patent ductus arteriosus, or ventricular septal defect may be cleared in concert with evaluation from cardiac and pulmonary specialists.

Pacemakers

Patients requiring permanent pacing should be disqualified because of their underlying cardiac pathology.

RESPIRATORY SYSTEM

A primary concern with the respiratory system and diving is the trapping of compressed gas within the lungs. As a diver respires at depth, the gas being exchanged is at greater than 1 atmosphere of pressure (every 34 feet of fresh water adds 1 atmosphere of pressure). If compressed gas becomes trapped in obstructed alveoli, when the diver ascends the gas will expand, rupturing the alveoli.

Asthma

In patients with bronchial asthma, bronchospasm can be triggered by many factors including several that are commonly encountered while diving. Breathing cold, dry air may precipitate bronchospasm as well as the vigorous exercise associated with diving. Aspiration of salt water and emotional stress encountered during equipment malfunction or other emergency are also triggering stimuli for bronchospasm.

Exercise-induced asthma (EIA) is a clinical syndrome of acute, reversible and usually self-limiting airway obstruction which develops after strenuous exercise. Drying of the airways with a subsequent loss of heat is the initial stimulus leading to an attack of EIA. Patients who may develop EIA include those with hay fever as well as with a past history of asthma but symptom-free for years. EIA can be induced by breathing the cold, dry air supplied by scuba regulators.

Any patient with currently active bronchial asthma should be strictly forbidden to dive. If bronchospasm occurs while breathing compressed gas at depth, the possibility of pulmonary barotrauma during ascent is greatly increased. Air trapped in obstructed alveoli will expand as the diver ascends, leading to rupture of the alveoli and possible pneumothorax, pneumomediastinum, subcutaneous emphysema or intravascular gas. Patients with a history of childhood asthma, symptoms suggestive of asthma within the past year, or suspicion

of exercise-induced asthma should be referred to a pulmonary medicine specialist for evaluation and challenge testing.

Pneumothorax

Spontaneous pneumothorax most commonly occurs secondary to rupture of an undetectable apical emphysematous bleb. A history of a spontaneous pneumothorax should be considered a disqualification for diving due to the risk of recurrence, which may be as high as 50%. Patients who have undergone chemical pleurodesis or pleurectomy are still at risk for contralateral pneumothorax and should continue to be disqualified.

Patients who have suffered a traumatic pneumothorax should be evaluated by a thoracic surgeon, pulmonary medicine specialist or diving medicine specialist in order to reach a decision regarding clearance to dive. Scarring and differential lung stiffness which could cause shearing with pressure imbalance and local air trapping leading to pneumothorax. Any active pulmonary infection or any sequelae such as fibrosis, cavitation, or emphysema are disqualification for diving.

NEUROLOGIC SYSTEM

Head Injury

Principle concerns for diving following head trauma are residual neurological defects and seizures. Amnesia that lasts greater than 4 weeks is evidence of significant brain damage and should cause disqualification from diving. In evaluating patients with less severe head trauma, a guide from aviation medicine can be utilized. With even momentary amnesia or unconsciousness, there is brain damage, but if all other studies are normal including stress EEG with no anticonvulsant medication, diving could be considered after six weeks. With longer periods of amnesia, return to diving is possible after six months following one week of amnesia, nine months following 2 weeks of amnesia and one year following three weeks of amnesia. In all cases these decisions should include the input of the patient's neurologist or neurosurgeon.

Seizures

Because of the risk of drowning, any seizure disorder is disqualifying regardless of control by anticonvulsant medication. The typical periodic breath holding during the tonic and clonic phases of a seizure make pulmonary barotrauma likely during uncontrolled ascent. The exceptions in allowing patients with a seizure history to dive would be patients with simple febrile seizures, neonatal seizures, or seizures secondary to sepsis, meningitis, drug ingestion or breath holding. The exceptions would be made only if the patient was otherwise normal neurologically and has a normal EEG as well as clearance from a neurologist.

Spinal Disease

If there are no neurological impairments in a patient with herniated nucleus pulposus, diving may be undertaken with caution with regard to lifting. If there is neurological impairment, diving should be forbidden until 3 months following resolution of symptoms. Altered sensation or muscular weakness resulting from a herniated nucleus pulposus may mimic or mask symptoms of decompression sickness, thus confusing and possibly delaying diagnosis. Because of the increased incidence of spinal cord decompression sickness after spinal trauma, a history of such trauma is a disqualification from diving.

Stroke

A history of a stroke or transient ischemic attack is reason for disqualification because of the increased likelihood of central nervous system decompression sickness.

Craniotomy

Diving after successful surgery for benign intracranial tumors, vascular disease, or aneurysms depends on absence of seizures, normal EEG, and individual evaluation from a neurosurgeon or neurologist.

OTORHINOLOGIC SYSTEM

Barotrauma involving the air-containing spaces of the head is the most frequently encountered medical problem in diving. Barotrauma of the ears, especially the middle ear, is by far the most common disorder among divers.

External Ear Disease

Any obstruction of the external ear canal which creates an unvented air space lateral to the tympanic membrane will cause an external ear squeeze as the ambient water pressure increases during descent. This can lead to pain, hemorrhage and perforation of the tympanic membrane. Any diver with a significant plug of earwax, swelling of the external ear canal secondary to infection, bony exostoses or congenital or acquired stenosis or atresia should not dive until the underlying obstruction has resolved.

Middle Ear Disease

Normal opening of the eustachian tubes is required for ventilation of the middle ear and mastoid air cell system. Failure of proper ventilation results in acute and chronic changes in the middle ear and represents the most important and frequently encountered cause of morbidity in the scuba diver. Pathological processes which may prevent autoinflation may be temporary such as acute upper respiratory infection, intermittent such as allergic rhinitis or possibly permanent such as cleft palate. Diving during an acute upper respiratory infection is discouraged because of difficulty equalizing the middle ear pressure as well as the paranasal sinuses. Additionally, there is a more serious risk of pulmonary air trapping during ascent due to the frequently associated bronchitis with upper respiratory infections. Allergic rhinitis is another condition which can cause edema

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and subsequent obstruction of nasal airways, eustachian tube ostia and paranasal sinus orifices. The diving candidate with allergic rhinitis has probably been aware of their condition for many years and should follow an on-going program for control of symptoms. Patients with acute phase allergic rhinitis should not dive until the acute phase has subsided and ear and sinus pressure equalization is free and easy. All patients with cleft palate have eustachian tube abnormalities, and although the defect may have been repaired, otologic evaluation prior to diving is advised to ensure patency of the eustachian tube. Patients with a bifid uvula may have an occult submucosal cleft of the soft palate which may cause inadequate eustachian tube function.

Any patient with tympanostomy tubes should not dive until the tubes have extruded, the tympanic membrane healed and normal eustachian tube function is demonstrated. Existing tympanic membrane perforations or tympanostomy tubes would allow access of water to the middle ear. The obvious risk of infection is not as important as the powerful caloric stimulus, resulting in severe disorientation and drowning. Persons with well-healed or surgically repaired perforations, or extensively scarred tympanic membranes may attempt to dive if adequate eustachian tube function can be demonstrated. They should be warned that they are at increased risk to develop tympanic membrane rupture with hearing loss, vertigo and infection should any pressure imbalance occur. The presence of a cholesteatoma or perforation with chronic otorrhea indicates chronic poor eustachian tube function. Otologic referral is mandatory and in all likelihood diving should never be permitted.

During examination the tympanic membrane should be seen by the examiner during autoinflation. Frequently the patient may report that the ears "pop", but movement is not seen. The only absolute way to test the eustachian tube and ensure adequate ventilation of the middle ear is to place the individual in a hyperbaric environment. The U.S. Navy requires that divers equalize pressures during compression to 50 psi in a hyperbaric chamber. Eustachian tube function represents the limiting factor in sport scuba diving and no dive should be undertaken without adequate function. Although not as reliable as a test under pressure and generally not needed among sport divers, tympanometry represents the best test of the eustachian tube available to most diving candidates. Meniere's disease or other vertiginous conditions are cause to disqualify a person from diving, including individuals who have undergone a variety of surgical procedures designed to arrest or resolve the symptoms of Meniere's disease.

Sinuses

The sinuses can also be affected by barotrauma. Normal nasal function is required for adequate sinus ventilation. Generally any abnormality in the nose can result in failure to properly ventilate the sinuses. Mucosal abnormalities are the most common and diving should be restricted during episodes of acute viral rhinitis. Anatomical obstructions such as deviated septum or nasal polyps may also impair sinus pressure equalization.

Larynx

Any condition involving the larynx that interferes with the protective function, produces incompetence or obstruction is cause to disqualify a candidate. Such conditions would include cyst, stenosis, neoplasm, vocal cord paralysis, loss of sensation secondary to laryngeal nerve damage, or a laryngocoele.

ORTHOPEDIC

Patients with fully healed artificial joints as well as plates, pins, screws, and other internal fixation devices can be cleared for diving.

MISCELLANEOUS

Diabetes

There is a great deal of controversy regarding diving by diabetic patients. Patients with end organ disease, ketoacidosis, or frequent episodes of hypoglycemia should be disqualified from diving. However, those with mild abnormalities of glucose metabolism fully controlled by weight loss and diet can be cleared. Conservative diving physicians feel that all insulin-dependent diabetics should be disqualified because of the disastrous consequences of a hypoglycemic episode at depth. Non-insulin dependent diabetics with a history of hypoglycemic episodes should also be disqualified from diving.

Thyroid Dysfunction

Patients with thyroid disorders that are under good control need not be disqualified if there are not any other complicating factors.

Pregnancy

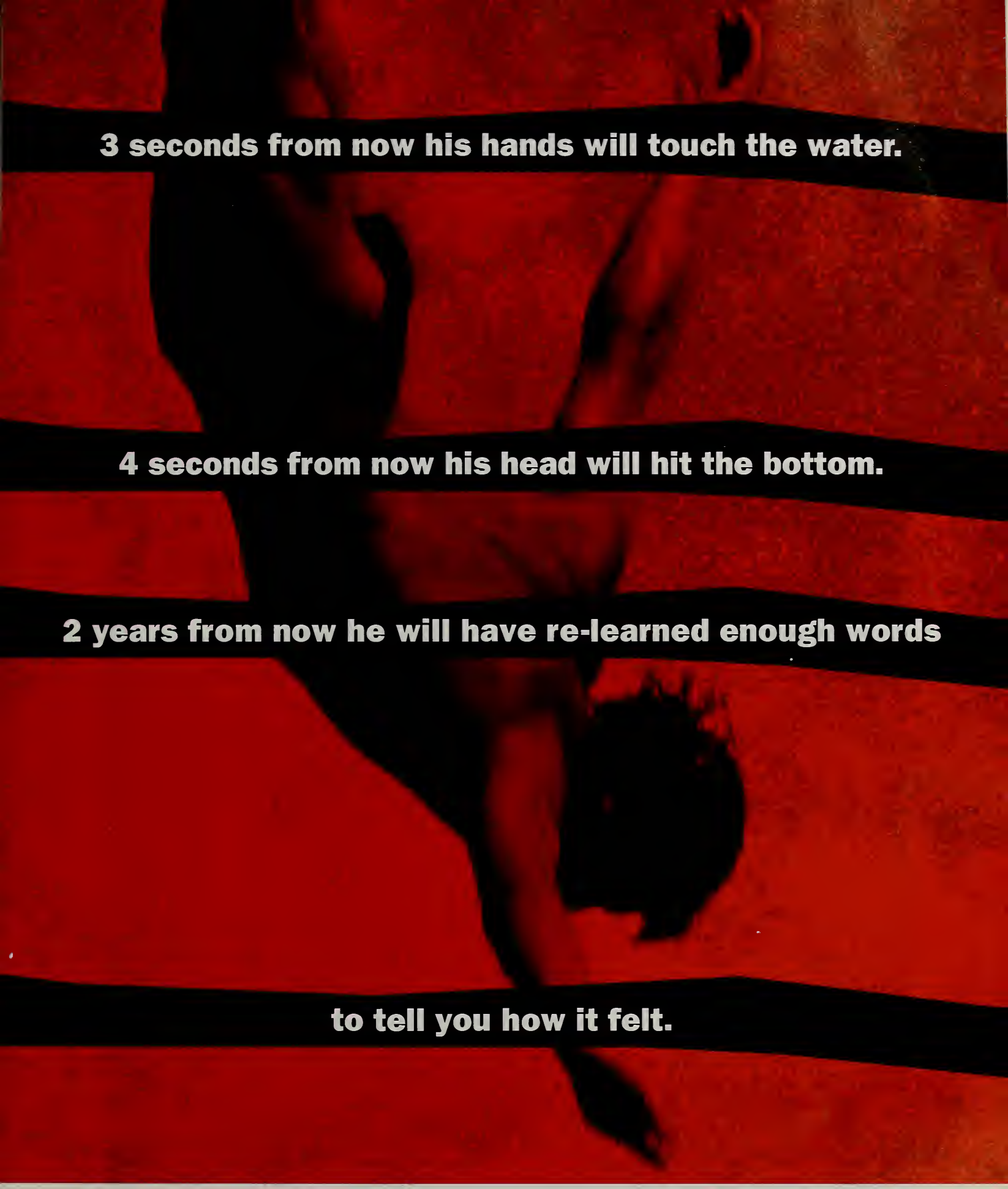
Pregnant females should be absolutely disqualified from diving based on the current experimental evidence available.

For questions or topics not covered in this review, the Divers Alert Network (DAN), based at the F.G. Hall Hyperbaric Center at Duke University, maintains a staff of hyperbaric physicians who are available for questions or referrals. Routine medical questions can be directed to DAN at 919-684-2948, while questions regarding diving emergencies should be directed to 919-684-8111, which is staffed on a 24 hour basis.

BIBLIOGRAPHY

Davis JC: Medical Examination of Sport Scuba Divers. San Antonio, Medical Seminars, Inc., 1986.

Bove AA, Davis JC: Diving Medicine. Philadelphia, W.B. Saunders Company, 1990.



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Arkansas HIV/AIDS Report 1983-1993

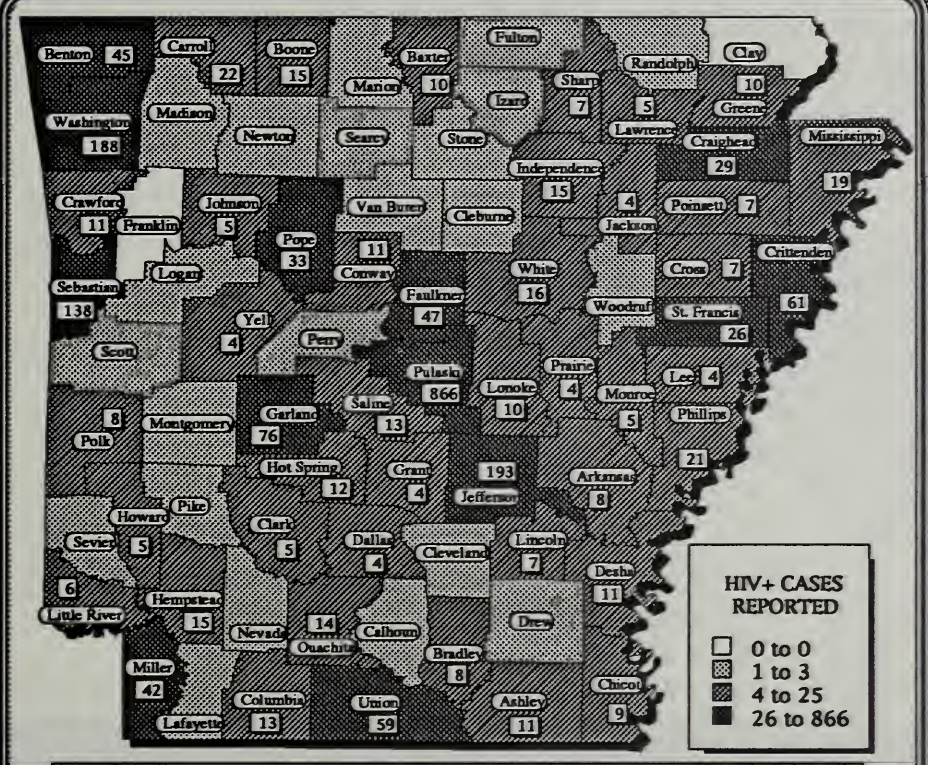
Arkansas: 1983 through February 25, 1993

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	19	32	49	216	251	437	421	408	56	1,889	85.21
	Female	1	1	6	27	39	72	89	83	10	328	14.79
AGE	< 5	0	0	1	1	2	9	14	8	0	35	1.58
	5-12	0	0	0	1	1	5	2	2	0	11	0.50
	13-19	0	0	0	8	8	14	20	26	2	78	3.52
	20-29	8	10	15	109	125	192	154	164	21	798	35.99
	30-39	7	15	22	86	105	206	219	185	29	874	39.42
	40-49	4	7	11	24	35	62	74	68	11	296	13.35
	> 49	1	1	6	6	12	19	23	38	3	109	4.92
	Unknown	0	0	0	8	2	2	4	0	0	16	0.72
RACE	White	16	24	47	171	178	353	312	302	43	1,446	65.22
	Black	4	9	8	70	107	153	195	179	20	745	33.60
	Other/Unknown	0	0	0	2	5	3	3	10	3	26	1.17
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	491	66	2,217	100%

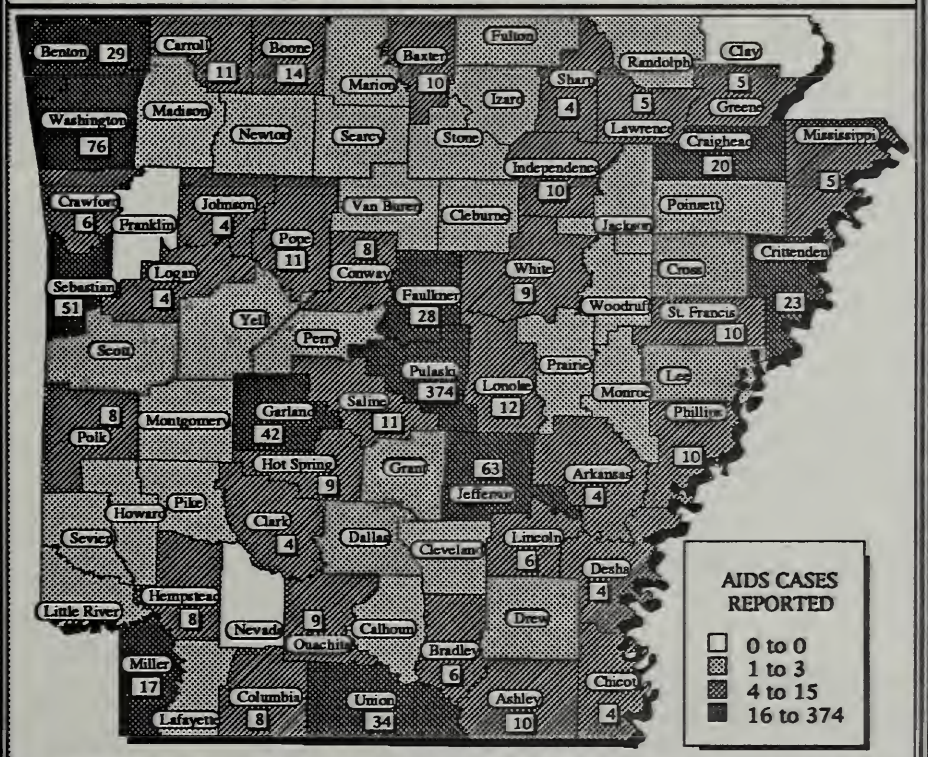
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	103	931	88.25
	Female	1	0	4	6	10	20	25	35	23	124	11.75
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.61
	5-12	0	0	0	1	0	1	1	0	0	3	0.28
	13-19	0	0	0	0	0	4	3	2	4	13	1.23
	20-29	7	9	15	27	24	55	57	81	35	310	29.38
	30-39	3	13	23	36	41	78	80	128	60	462	43.79
	40-49	1	6	8	10	7	35	41	52	21	181	17.16
	> 49	1	0	4	8	7	11	13	19	6	69	6.54
RACE	White	9	22	43	61	58	141	134	207	92	767	72.70
	Black	3	6	7	20	21	47	66	74	32	276	26.16
	Other/Unknown	0	0	0	2	1	2	1	4	2	12	1.14
RISK	Male/Male Sex	7	17	31	59	50	118	118	177	67	644	61.04
	Injection Drug User (IDU)	0	2	10	4	11	18	28	40	18	131	12.42
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	8	89	8.44
	Heterosexual	2	0	2	3	6	10	10	22	9	64	6.07
	Transfusion	0	0	2	7	3	7	11	3	1	34	3.22
	Perinatal	0	0	0	1	1	6	6	3	0	17	1.61
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.99
	Undetermined	0	0	1	2	2	8	6	18	18	55	5.21
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	126	1,055	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1993



County of residence at the time of test for the 2217 Arkansans reported to be HIV+. (2/25/93)



Of the 2217 Arkansans reported to be HIV+, 1055 have been diagnosed with AIDS. (2/25/93)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

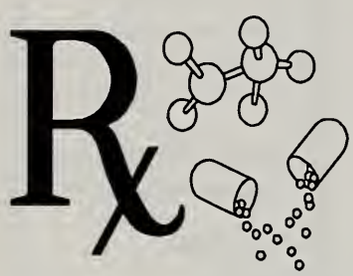
Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas Medical Society

SIXTH ANNUAL AIDS SEMINAR

The Arkansas Medical Society will host the Sixth Annual AIDS Seminar on Saturday, May 22, 1993 at the Ramada Inn in Hot Springs, Arkansas. The program will begin at noon with a luncheon. The keynote presentation will be followed with a panel discussion of Arkansas clinicians.

The keynote speaker will be Robert T. Schooley, M.D., Professor of Medicine, Head of Infectious Disease Division, University of Colorado Health Sciences Campus in Denver, Colorado. Dr. Schooley is also on the Burroughs Wellcome Co.'s HIV Management Council.



Dr. Schooley's presentation will update health care professionals on treatment of the latter stages of HIV disease, including new drugs and other modalities.

Registration information will be mailed to your office. The AMS Committee on AIDS encourages all Society members to attend, as well as any other interested health care professional.

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Since 1989 AHCAF has reached thousands of people and led, by example, in the quest for broader access to medical care. And with your continued support we will ensure the health and welfare of all Arkansans.

For more information on how you can help, call AHCAF at (501) 221-3033 or (800) 950-8233

Arkansas Health Care Access Foundation, Inc.

Medicine in the News

Health Care Access Foundation Update

As of March 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 5,581 medically indigent persons, received 11,292 applications, and enrolled 23,195 persons.

The program has 1,476 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

ADD Project Underway at Arkansas Children's Hospital

Arkansas Children's Hospital has received funding from the U.S. Department of Education's Office of Special Education and Rehabilitative Services for a five-year project to develop, evaluate and distribute a model Attention Deficit Disorder (ADD) inservice training program for special education teachers, regular classroom teachers, school administrators, school counselors, school nurses and related personnel.

ADD is a widely misunderstood developmental disability estimated to affect between 3 and 4 percent of all children. Also called Attention Deficit Hyperactivity Disorder, ADD is characterized by three predominant features: inattentiveness, impulsivity and, in many but not all cases, restlessness or hyperactivity. The disorder is most prevalent in children and is generally thought of as a childhood disorder.

The purpose of the program is to increase awareness of the characteristics, assessment and management of ADD and to provide training in the implementation of behavioral techniques to meet the instructional needs of children with ADD.

This project will enhance educators' ability to identify children with ADD who are at risk for decreased academic functioning, promote educators' understanding of the effects and side effects of psychostimulant medications and increase educators' competence in implementing specific environmental and behavioral interventions.

Through the grant, a model for training educational and school nurse inservice trainees will be developed and evaluated. This model may impact more educators, and indirectly, more children with ADD, by increasing the accessibility and distribution of the model ADD inservice program.

A team of personnel from psychology, developmental pediatrics, social work and education has been assembled at Arkansas Children's Hospital to serve as staff members for the project. Staff members will work cooperatively with the Arkansas Department of Education's Special Education Division. The inservice staff also will collaborate with state's educational cooperatives and teacher organizations to disseminate the model ADD inservice program.

Medicare-eligible Persons Who Have End-stage Kidney Disease Are Now Eligible for CHAMPUS

Persons under age 65 who lost their CHAMPUS eligibility when they became entitled to Medicare Part A (hospital services) benefits because of end-stage kidney disease, have had their CHAMPUS benefits restored.

The restored benefit is effective for care received on or after October 1, 1991, by people in the above group who are also enrolled in Medicare Part B (professional services).

End-stage kidney disease patients were restored to CHAMPUS eligibility by the Defense Authorization Act for 1993.

AMA Receives Grant From Burroughs-Wellcome Company

A $60,000 educational grant from the Burroughs-Wellcome Co. will support an AMA international meeting this summer in Berlin, Germany. The meeting, coordinated by the AMA Division of Health Science, will address the topic of early HIV treatment. It will immediately precede the International AIDS Conference.

May - National Health Month, 1993 Planning Guide Available

Health and mental health professionals, educators, and clergy who are planning community outreach programs during May, National Mental Health Month, can now access the resources and program ideas of the American Psychiatric Association (APA) and National Mental Health Association (NMHA).

The "Idea & Information Exchange for Mental Health Month," compiled and produced jointly by the APA and NMHA, pools information from across the nation on successful, locally planned and conducted Mental Health Month activities. The 36-page booklet features camera-ready art work, histories and backgrounders about the month-long observance, and a calendar of programs and ideas proven successful by local affiliates of NMHA, APA and other mental health awareness advocacy organizations.

The booklet is available to all organizations and facilities interested in participating at $2 each. To order, call (202) 682-6220.

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M.O.M.S., Inc., wishes to thank the physicians, administrators, office managers, and clinic staff members who have played such significant roles in the success of our company as recognized by Arkansas Business at their recent awards ceremony. Clients, friends, supporters have challenged and encouraged us to reach, to stretch and to come even closer toward our goal of truly efficient and effective office management assistance.

New Members

BENTON COUNTY

Friesen, Douglas L., General Surgery, Rogers. Born January 20, 1957. Medical education, University of Kansas School of Medicine, Kansas City, Kansas, 1983. Residency, University of Kansas - St. Francis Regional Medical Center, Wichita, 1988. Board certified.

CRAIGHEAD COUNTY

Lynch, John K., Radiation Oncology, Jonesboro. Born June 9, 1961. Medical education, University of Health Sciences, Kansas City, Missouri, 1987. Internship, Riverside Osteopathic Hospital, Trenton, Michigan, 1988. Residency, Detroit Osteopathic Hospital, Detroit, 1991. Board certified.

Plunk, Hermie G., Family Practice, Jonesboro. Born October 21, 1934. Medical education, University of Tennessee, 1965. Internship, St. Joseph's Hospital, Memphis, 1966.

Zurkowski, Thomas M., Psychiatry, Jonesboro. Born May 7, 1938. Medical education, Creighton University College of Medicine, Omaha, 1966. Internship, U.S. P.H.S. Hospital, Baltimore, 1967. Residency, Tulane, New Orleans/Akron Med. Center, Akron, 1991.

DESHA COUNTY

Asemota, Oboma S., General Surgery, Dumas. Born December 26, 1946. Medical education, University of Ibadan Medical School, Nigeria, 1971. University of Benin Teaching Hospital, Nigeria, 1972. Residency, New Castle General Hospital, Hammersmith Hospital and Buerton General Hospital, England, 1977. Board certified.

FAULKNER COUNTY

Bell, Floyd K., Diagnostic Radiology, Conway. Born July 8, 1956. Medical education, UAMS, 1982. Residency, UAMS, 1986. Board certified.

GARLAND COUNTY

Daniel, Robert G., Internal Medicine, Hot Springs. Born October 6, 1954. Medical education, UAMS, 1987. Internship/Residency, University Of Missouri Hospital and Clinics, Columbia, 1990. Board certified.

Sousan, Leo, OB/GYN, Hot Springs. Born October 15, 1952. Medical education, University of Toronto, Ontario, Canada, 1981. Internship, St. Michael's Hospital, Toronto, 1982. Residency, University of Toronto, 1986. Board eligible.

PULASKI COUNTY

Altman, Carolyn A., Pediatric Cardiology, Little Rock. Born September 22, 1959. Medical education, University of Pittsburgh, 1986. Internship/Residency, Children's Hospital of Pittsburgh, 1989. Board certified.

Bond, Jeffrey B., Ophthalmology, Little Rock. Born July 17, 1961. Medical education, Vanderbilt University School of Medicine, Nashville, 1987. Internship/Residency, Tulane University School of Medicine, 1991. Board certified.

Burnett, P. Susan, Anesthesiology, Little Rock. Born December 6, 1953. Medical education, UAMS, 1979. Internship/Residency, North Carolina Baptist Hospital, 1982. Board certified.

Calhoun, Susan V., Anesthesiology, Little Rock. Born April 12, 1958. Medical education, Howard University College of Medicine, Washington, D.C., 1984. Internship/Residency, Howard University Hospital, 1987.

Fawcett, Deborah D., Pediatrics, Little Rock. Born May 2, 1952. Medical education, UAMS, 1977. Internship/Residency, Arkansas Children's Hospital/UAMS, 1980. Board certified.

Shewmake, Kristopher B., Plastic and Reconstructive Surgery, Little Rock. Born August 10, 1955. Medical education, UAMS, 1984. Internship/Residency, UAMS, 1992.

RANDOLPH COUNTY

Agent, William S., Surgery, Pocahontas. Born February 2, 1940. Medical education Kansas City College of Osteopathic Medicine.

SALINE COUNTY

Vice, Mark A., Family Practice, Benton. Born October 23, 1961. Medical education, UAMS, 1989. Internship/Residency, UAMS - AHEC Pine Bluff, 1992. Board certified.

SEBASTIAN COUNTY

Balsara, Zubin N., Radiology, Fort Smith. Born October 9, 1957. Medical education, University of Miami Medical School, 1982. Internship, US Naval Hospital, Portsmouth, 1983. Residency, USNH, San Diego, 1990. Board certified.

Borklund, Maurice K., Family Practice, Fort Smith. Born April 23, 1921. Medical education, Indiana University School of Medicine, 1950. Internship/Residency, Kansas City General Hospital, 1955. Board certified.

Fleck, Randolph P., Cardiovascular Diseases, Fort Smith. Born December 16, 1956. Medical education, Loyola University Stritch School of Medicine, Maywood, Illinois, 1982. Internship, Naval Regional Medical Center, San Diego, 1983. Residency, Naval Hospital, San Diego, 1986. Fellowship, Naval Hospital, San Diego, & UCSD, 1989. Board certified.

Fleck, Rebecca A., Hematology, Fort Smith. Born April 21, 1956. Medical education, Loyola University Stritch School of Medicine, Maywood, Illinois, 1982. Internship, University of California, Los Angeles, 1985. Residency, University of California, San Diego, 1987. Board certified.

Sanders, Robert V., III, Pulmonary Diseases, Fort Smith. Born February 10, 1954. Medical education, University of Alabama, Birmingham, 1979. Internship/Residency, Carraway Methodist Medical Center, 1982. Fellowship, University of South Alabama, Mobile, 1984. Board certified.

VAN BUREN COUNTY

Starnes, Harry D., Family Practice & Industrial Medicine, Clinton. Born June 18, 1941. Medical education, UAMS, 1968. Internship, Lackland Air Force Base, San Antonio, 1969.

WASHINGTON COUNTY

Sandefur, Barbara A., Diagnostic Radiology, Springdale. Born December 18, 1951. Medical education, LSU Medical Center, New Orleans, 1978. Internship, Marshfield Clinic, Marshfield, Wisconsin, 1980. Residency, UAMS, 1984. Board certified.

OUT OF STATE

Florendo, Noel T., Pathology, Memphis, Tennessee. Born November 11, 1944. Medical education, University of Tennessee College of Medicine, 1974. Internship/Residency, Baptist Memorial Hospital, 1978. Board certified.

RESIDENTS

Barnes, Greg F., OB/GYN. Born July 1, 1963. Medical education, UAMS, 1989. Internship/Residency, University Hospital.

Clay, Donald G., Psychiatry. Born May 21, 1957. Medical education, UAMS, 1991. Residency, UAMS.

Dunbar-Davies, Winnifred J., Family Practice. Born November 27, 1957. Medical education, UAMS, 1991. Residency, UAMS.

Edwards, Carl B., OB/GYN. Born July 15, 1960. Medical education, East Tennessee State University, Johnson City, 1989. Internship/Residency, LSU.

Perret, Kenneth A., Internal Medicine. Born November 10, 1963. Medical education, UAMS, 1990. Internship/Residency, UAMS.

Shutt, Bryce C., Ophthalmology. Born October 6, 1964. Medical education, Baylor College of Medicine, 1991. Internship/Residency, UAMS.

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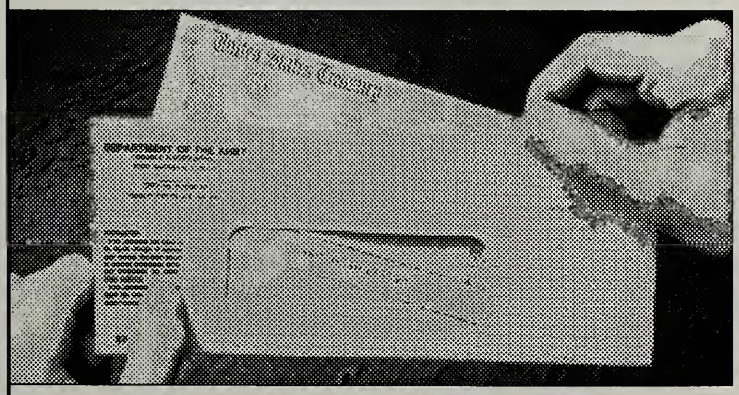

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Associate Director of Clinical Research
Institute for Drug Development
Cancer Therapy and Research Center
San Antonio, Texas

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The important advances, new technologies and treatment modalities in oncology research.

Tim Webb, M.D.
Oncologist

TOPIC:
The therapeutic options in the treatment of prostate cancer.

Robert Aspel, M.D.
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TOPIC:
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AMS Newsmakers

Dr. Morgan Collins and **Dr. James T. Meredith,** both with practices in Forrest City, are among the first in the nation to employ a new device aimed at eliminating Medicaid fraud.

The two doctors' clinics are using the Automated Eligibility Verification and Claim Submission (AEVCS) program created by EDS (Electronic Data System) of Texas.

Dr. James Deneke, a board certified rheumatologist associated with Cooper Clinic and co-director of the Cooper Clinic Osteoporosis Center in Fort Smith, recently attended a conference on clinical management of patients with osteoporosis presented by the National Osteoporosis Foundation and the University of Texas Health Science Center at San Antonio, Texas.

Dr. Leo Drolshagen III, medical director of MRI at St. Edward in Fort Smith, has been elected chief of staff of St. Edward Mercy Medical Center for 1993. **Dr. John Weisse,** a private practice surgeon in Fort Smith, has been named chief of staff-elect. **Dr. William Dudding** of Eastside Family Practice has been elected secretary.

Dr. Joycelyn Elders, U.S. surgeon general-designate, was honored in Washington as one of 13 black Americans who have made outstanding contributions in the most critical areas of care facing their race. Elders was honored at a reception by the Congressional Black Caucus and Aetna Life & Casualty.

Dr. Vida H. Gordon, retired pediatric allergist of Little Rock, was recently spotlighted in the High Profile section of the *Arkansas Democrat Gazette* for her contributions to the field during the 50 years she practiced. Among her accomplishments, Dr. Gordon was the state's first board-certified allergist, pediatric allergist and the founder of the state's first certified training program for allergists. She also founded the Alan G. Cazort Society of Allergy and Immunology and served as chief of staff at Arkansas Children's Hospital in the early '60s.

Dr. F. Hampton Roy, an ophthalmologist of Little Rock, was elected as Secretary/Treasurer of the American College of Eye Surgeons at its annual meeting held at the Fairmont Hotel in San Fransisco.

Dr. John P. Shock, chairman of the department of ophthalmology in the College of Medicine at the University of Arkansas for Medical Sciences, has received a $50,000 grant from Research to Prevent Blindness.

In Memoriam

Geneva H. Edwards

Geneva H. Edwards, of Searcy, died Thursday, January 21, 1993. She was 77.

Survivors are her husband, Dr. Hugh R. Edwards; a daughter, Marcia Darr of Little Rock; a son, Robert Edwards of Searcy; a brother, John L. Hargis of Morrilton; and four grandchildren.

William J. Flanigan, M.D.

Dr. William J. Flanigan, of Little Rock, died Tuesday, March 2, 1993. He was 62.

Survivors are his wife, Yvonne Robinson Flanigan; two sons, Steven Flanigan of Little Rock and Patrick Flanigan of Memphis; two daughters, Tammy Flanigan Chrestman of Little Rock and Leslie Flanigan Riddel of Mesquite, Texas; his mother, Edith Reville Flanigan of Little Rock; a sister, Jerry Stough of Hot Springs; and six grandchildren.

Curtis E. Ripley, M.D.

Dr. Curtis E. Ripley, of Crossett, died Saturday, February 20, 1993. He was 61.

Survivors are his wife, Betty Ripley; two sons, Randy Ripley and Roger Ripley, both of Little Rock; a daughter, Lynn Walton of Batesville; a sister, Sue Ross of Little Rock; and six grandchildren.

Resolution

William J. Flanigan, M.D.

Whereas, the membership of the Pulaski County Medical Society observes with sadness the recent death of their respected colleague, William J. Flanigan, M.D.; and

Whereas, Dr. Flanigan was a loyal member of this Society for many years and was widely recognized for his contributions to his chosen field of Nephrology; and

Whereas, Dr. Flanigan will long be remembered for the empathy he manifested toward his patients and for his many years of service to the Lions International Eye and Kidney bank; be it therefore

RESOLVED, that this resolution be adopted and placed in the permanent archives of this Society; and

RESOLVED, that a copy be mailed to Dr. Flanigan's family as an expression of our heart-felt sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 17, 1993

By Order of the Memorials Committee
Bruce E. Schratz, M.D.
Henry Hollenberg, M.D.
Robert Watson, M.D.

John V. Satterfield, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of our esteemed colleague, John V. Satterfield, M.D.; and

Whereas, he was a faithful member of this organization for twenty-eight years, giving freely of his time and energy to promote the interests of his patients and his fellow physicians; and

Whereas, Dr. Satterfield was admired by his patients, his peers, and the community at large for the expertise and compassion he displayed in the practice of medicine; be it therefore

RESOLVED, that this resolution be adopted and made a part of the permanent records of this Society; and

RESOLVED, that a copy be forwarded to Dr. Satterfield's family as a token of our heart-felt sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 17, 1993

By Order of the Memorials Committee
Bruce E. Schratz, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

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Arkansas Medical Society
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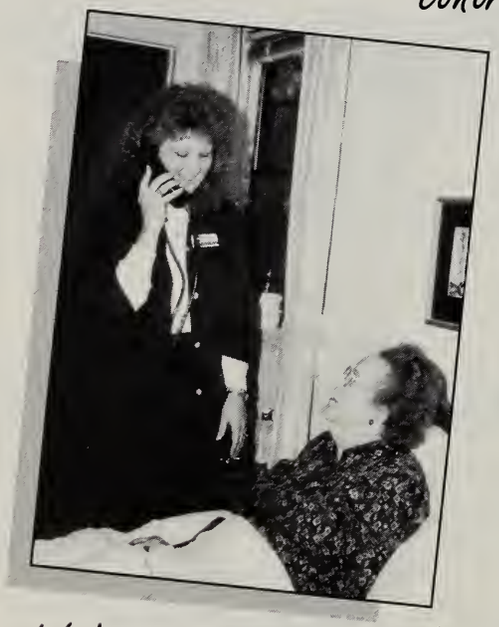

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health care at home
arkansas department of health

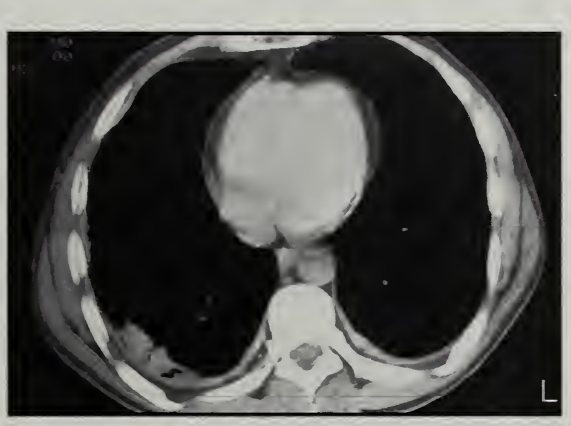
Radiological Case of the Month

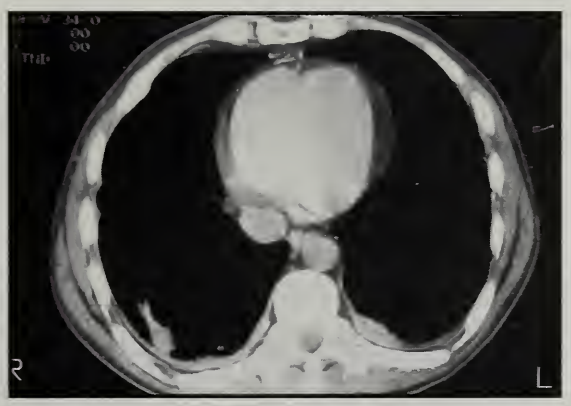
W. Bradley Pierce, M.D.
John C. Schultz, M.D.
Edward Loebl, M.D.
Steven R. Nokes, M.D.

History:

This 45-year-old man with a history of asbestos exposure presented with a pulmonary mass on a chest radiograph (Figure 1). A CT scan was then obtained (Figures 2,3,4).

Figure 1





Right from top: Figures 2-4

Asbestosis-related round atelectasis.

Findings:

The PA chest (Figure 1) reveals a vague density in the right lung base. The CT scans reveal bilateral pleural thickening with calcification associated with a mass in the right lower lobe (Figures 2 and 3). There is a "comet tail" of bronchi and vessels associated with the mass, seen best on the high resolution lung setting (Figure 4).

Discussion:

A number of focal pulmonary and pleural masses are associated with asbestos exposure. The risk of bronchogenic carcinoma in asbestos workers is five times that of the unexposed population and 50-90 times greater in asbestos workers who smoke. There is also a strong causal relationship between asbestos exposure and malignant mesothelioma.

Round atelectasis is a benign pseudotumor that may occur in patients with asbestosis. It represents atelectasis of the peripheral lung resulting from pleural adhesions and fibrosis. It most commonly occurs in the posterior lung bases. Masses adjacent to focal pleural plaques are unlikely to be round atelectasis which usually is accompanied by diffuse pleural thickening.

The classic CT criteria for round atelectasis include:
(a) a mass in contiguity with pleural thickening;
(b) volume loss of the affected lobe;
(c) a round, lentiform, or wedge shaped mass; and
(d) visualization of bronchovascular structures, so-called "comet tail" sweeping into the mass.

If CT features are typical of round atelectasis in a patient with asbestosis, close follow-up can obviate biopsy in most instances. Any change on follow-up or any equivocal findings should prompt a biopsy. In this case the diagnosis was made at thoroscopy.

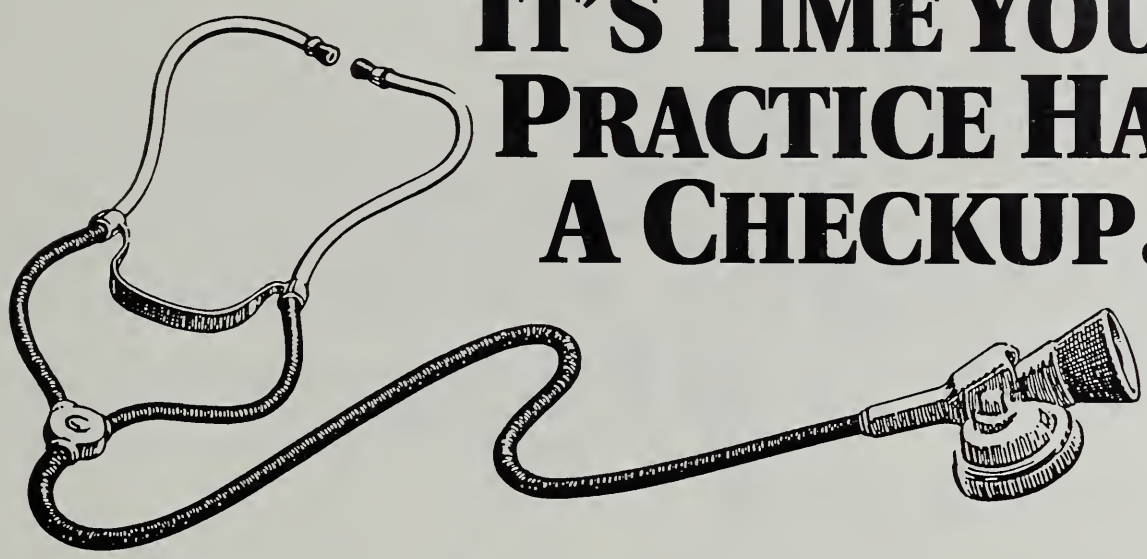
References:

Lynch DA, Gamsu G, Ray CS, Aberle DR. Asbestos-related focal lung masses: manifestations on conventional and high-resolution CT scans. Radiology 1988; 169:603-607.

Aberle DR. High-resolution computed tomography of asbestosis-related diseases. Seminars in Roentgenology 1991; Vol XXVI, No 2:118-131.

Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.
Contributor: W. Bradley Pierce, M.D., is affiliated with Radiology Consultants in Little Rock.
Contributor: John C. Schultz, M.D., is affiliated with the Little Rock Diagnostic Clinic in Little Rock.
Contributor: Edward Loebl, M.D., is affiliated with Arkansas Vascular in Little Rock.

IT'S TIME YOUR PRACTICE HAD A CHECKUP...



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Would your practice's rent or mortgage be paid?	☐ Yes	☐ No
Would your employees' salaries be paid?	☐ Yes	☐ No
Would your employees receive the benefits you promised them?	☐ Yes	☐ No
Would installments or lease payments on office equipment be paid?	☐ Yes	☐ No
Would your professional liability insurance premiums be paid?	☐ Yes	☐ No
Would your property and casualty insurance premiums be paid?	☐ Yes	☐ No
Would your practice's taxes be paid?	☐ Yes	☐ No
Would your practice's utility bills be paid?	☐ Yes	☐ No
Would professional or trade dues be paid?	☐ Yes	☐ No
Would your accounting, billing, and collection fees be paid?	☐ Yes	☐ No
Would your mailing and subscription costs be paid?	☐ Yes	☐ No

If you checked "No" to any of these questions, your practice failed the checkup.
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Things To Come

April 29-May 1

12th Annual Conference on Child Abuse and Neglect. Red Lion Inn, Sacramento, California. Sponsored by Office of Continuing Medical Education, University of California-Davis School of Medicine and Medical Center. 12 hours Category I CME credit offered. For more information, call (916) 734-5390.

19th Annual Meeting of the Federated Ambulatory Surgery Association. Sheraton Harbor Island Hotel, San Diego, CA. For more information, call (703) 836-8808.

April 29-May 2

Clinical Electrocardiography: Basic Concepts & Interpretation - 13th Edition. Ritz-Carlton Hotel, Philadelphia, PA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME accreditation offered. For more information, call (804) 446-6143.

April 30-May 1

Hearing Aid Conference. Frontenac Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

April 30-May 2

Pathology of HIV. Arlington, VA. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, (202) 992-4285.

April 30-May 3

Annual Clinical Research Meeting. Washington, D.C. Sponsored by the Association of American Physicians, The American Society for Clinical Investigation, and the American Federation for Clinical Research. For more information, call (609) 848-1000.

May 1

Primary Care Cardiology. Hilton Hotel, Stockton, California. Sponsored by UC Davis School of Medicine and Medical Center. & hours Category I credit. For more information, call (916) 734-5390.

Depression and Related Disorders in Women. Doubletree Conference Center, Chesterfield, Missouri. Sponsored by the Washington University School of Medicine. 6 hours Category I credit available. For more information, call (800) 325-9862.

May 5

Update in Thoracic Surgery. Washington University Medical Center, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

Update in General Thoracic Surgery. Wohl Auditorium, Washington University Medical Center, St. Louis, Missouri. 6 hours Category I credit offered. For more information, call (800) 325-9862.

May 6-7

AMCRA's Managed Behavioral Health Care Conference. Forum Hotel Chicago. Presented by the American Managed Care and Review Association. Up to 12 hours Category I credit available. For more information, call (202) 728-0506.

May 6-9

Practical Dermatology for the Primary Care Physician - 19th Edition. Ritz-Carlton Hotel, Pentagon City, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

May 8

Epilepsy Update 1993. Cancer Center Auditoruim, UC Davis Medical center, Sacramento, CA. 7 hours Category I credit. For information, call (916) 734-5390.

May 13

Current Perspectives in Menopausal Problems. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

May 13-16

Central Atlantic Seminar in Anesthesiology. Washington, D.C. Sponsored by The George Washington University Medical Center, Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

May 14-15

Safety/Biosafety in the Workplace - Are You Prepared to Meet the Challenge? Hyatt New Orleans in Louisiana. Sponsored by the American Association of Blood Banks and the Council of Community Blood Centers. For more information (202) 393-1282.

May 19

"Changes in AABB Standards: 15th Edition" Teleconference, 2:00-3:45 p.m. EST. To locate a nearby teleconference sit, contact the AABB Education Department at (301) 215-6482.

May 21-22

Third Annual Cardiovascular Disease Review and Update For Primary Care Practitioners. Drake Hotel, Chicago, IL. Sponsored by Rush Medical College. 11.5 hours of Category I CME credit offered. For more information, call (201) 385-8080.

June 3-5

3rd International Biological Effects of Light Symposium. Wenkenhof Riehen meeting Center, Basel, Switzerland. Sponsored by the Light Symposium Foundation. For more information, call (404) 432-2409.

Arkansas, Fort Smith

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or

Michael Moody, M.D.
Family Clinic
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Salem, AR 72576
(501) 895-2541

June 4-5

12th Annual Occupational & Environmental Medicine Symposium. Cancer Center Auditorium, UC Davis Medical Center, Sacramento, CA. For information, call (916) 734-5390.

June 6-11

9th Annual EVMS Family Medicine Review Course. The Cavalier Hotel, Virginia Beach, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

June 11-12

Alzheimer's Disease. Adam's Mark Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

June 12-16

Board Review in Family Practice. Arlington, VA. Sponsored by The George Washington University Medical Center. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

June 13-18

17th Annual Fingers to the Toes: Primary Care Orthopaedics. Fallen Leaf Lake (South Lake Tahoe), CA. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. CME credit offered. For more information, call (916) 734-5390.

June 17-18

Allergic Diseases of the Upper and Lower Airways. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

Pediatric Transfusion Medicine: Present Practice and Future Directions. Hyatt Regency Bethesda in Bethesda, Maryland. Cosponsored by the AABB and TMAA. For more information, call (301) 215-6382.

June 25-27

11th Summer Symposium in Internal Medicine. Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

July 6-10

16th Annual Flap Dissection Workshop. Virginia Beach Conference Center, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

July 15-17

First Annual Mid-South Symposium on Cardiovascular Disease. The Laurence A. Grossman Medical Learning Center, Saint Thomas Hospital, Nashville, Tennessee. Sponsored by the American College of Cardiology. 18.5 Category I credit. For more information, call (800) 257-4739 (outside the U.S. and Canada, (301) 897-2695).

July 17-23

18th Annual National Wellness Conference. University of Wisconsin-Stevens Point, Wisconsin. For more information, call (715) 346-2172.

July 21-25

15th Annual National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum. Houston, TX. Sponsored by The George Washington University Medical Center Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of Continuing Medical Education, (202) 994-4285.

July 27-August 1

55th Annual Meeting of the International College of Surgeons-U.S. Section, held in conjunction with the 33rd North American Federation Congress. Westin Hotel, Seattle, WA. For more information, call (312) 787-6274.

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Golf Tournament for Members and Exhibitors on Thursday morning ◆ Welcome reception on Thursday afternoon, followed by the 1st House of Delegates ◆ Blue Cross Blue Shield Reception on Thursday evening ◆ Shuffield Luncheon on Friday at noon ◆ A Western Hoedown on Friday evening ◆ Exhibits and CME Sessions on Thursday and Friday ◆ The Final House of Delegates on Saturday morning ◆ Derby Day at Oaklawn on Saturday afternoon ◆ The AMS Inaugural Banquet on Saturday evening, followed by the President's Reception.

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Arkansas Medical Society
117th Annual Session
Arlington Hotel Hot Springs
April 15 - 17, 1993

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Keeping Up

Annual W.W. Stead Chest Symposium

April 24-25, 7:30, Fairfield Bay Resort and Conference Center. Sponsored by UAMS and presented by Marcia L. Erbland. 7.25 Category I credit. Fee: Physicians, $50; Others, $25.

Annual Family Practice Intensive Review

April 30-May 2, time to be announced, UAMS Education II Building, Little Rock. Sponsored by UAMS and presented by R. Jerry Mann, M.D. and Mary Lindsey, L.C.S.W. Approximately 20 hours Category I credit. Standard fee: $300; Early fee (before April 14): $275.

Risky Business: Prenatal Alcohol Use and Postnatal Outcome

May 7, 9:00 a.m.-4:00 p.m., Arkansas Children's Hospital, Sturgis Auditoruim, Little Rock. Sponsored by Arkansas Children's Hospital. 5.5 Category I credit, fee: $50.

Use of Colony Stimulating Factors - Special Session of the Interdisciplinary AIDS Conference

May 14, 12 noon, St. Vincent Infirmary Medical center, Center for Health Education, Southwestern Bell/Arkla Rooms, Little Rock. Sponsored by St. Vincent Infirmary medical Center and presented by Alexandra M. Levine, M.D. One hour Category I credit, no fee. Seating limited, lunch provided.

Vector Infections

May 18, 6:30 p.m., Baxter County Regional Education Bldg., Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Eleanor Lipsmeyer, M.D. 2.0 Category I credit.

Family Medicine Spring Academic Conference

May 21-23, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information, contact Dr. Gene Aist at (501) 686-6628.

Envolving Issues in Vascular Biology and Coronary Heart Disease

May 22, 8:30 a.m., UAMS Education II Building, Room G141 A & B, Little Rock. Sponsored by UAMS and presented by Jon P. Lindemann, M.D. 2.75 Category I credit, fee: $25.

9th Annual Surgery Residents Day Conference

May 28, 12 noon, UAMS, ACRC Building, Little Rock. Sponsored by UAMS and presented by Robert W. Barnes, M.D. 3.5 Category I credit.

UAMS College of Medicine Alumni Weekend

June 11-13, Capital and Excelsior Hotels, Little Rock. Sponsored by the Arkansas Caduceus Club, College of Medicine Alumni Association. For more information, call (501) 686-6684.

Arkansas Caduceus Club Scientific Session

June 12, time to be announced, UAMS Education II Building, Little Rock. Sponsored by UAMS. Category I credit available.

Advances in the Management of Benign Prostatic Hyperplasia

June 15, 6:30 p.m., Baxter County Regional Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert P. Nelson, Jr., M.D. 2.0 Category I credit.

46th AAFP Annual Scientific Assembly

July 29-August 1, Excelsior Hotel and Statehous Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE-VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon for Medical/Dental Staff, May 14 & 28, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon

CME Luncheon, April 9 & 23, May 14 & 28, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL
Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
(THE AIDS CONFERENCE FOR APRIL IS CANCELLED FOR GOOD FRIDAY)

LITTLE ROCK-BAPTIST MEDICAL CENTER
Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL
Chest & Problems Case Conference, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Medicine Conference, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.
Surgery Conference, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Tumor Conference, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29

GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, 4th Thursday, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Pre-op/Didactic Conference, Mondays, 5:00 p.m., VAMC-LR, 4D
Urology Radiology Conference, 1st Thursday, 5:00 p.m., UAMS, Radiology Department
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Urology VA Teaching Rounds, every Friday, 7:30 a.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO-AHEC
Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital

Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC - South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

FAYETTEVILLE-AHEC NORTHWEST
AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH-AHEC
Advances in Plastic Surgery, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith
Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Osteoporosis, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith
Sparks Tumor Conference, Tuesdays, 12:00 noon, Sparks Regional Medical Center
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST
AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC
Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST
Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General.**)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N=900)	Placebo (N=411)	Pravastatin (N=900)	Placebo (N=411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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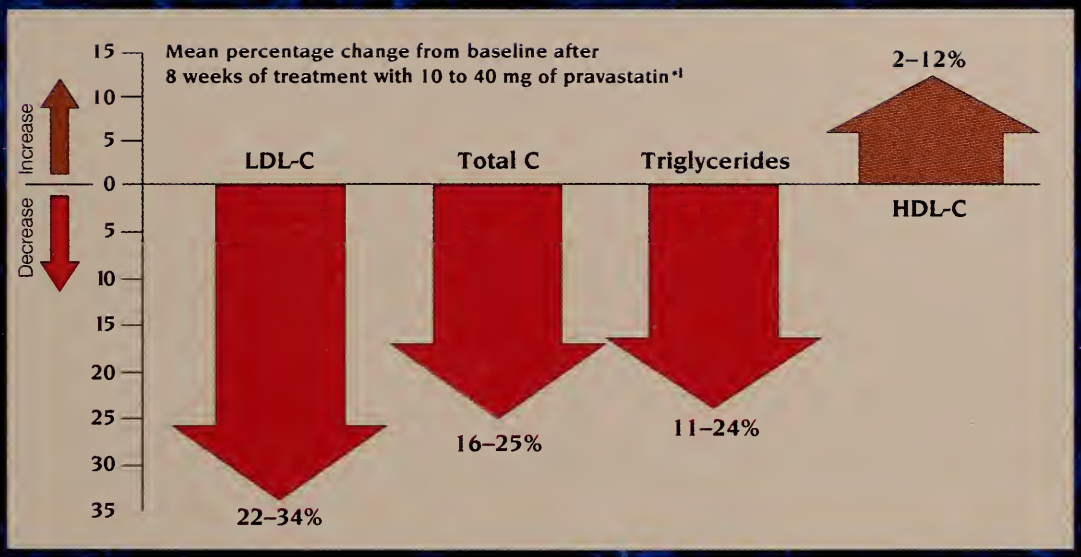

*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease *or* unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL™
pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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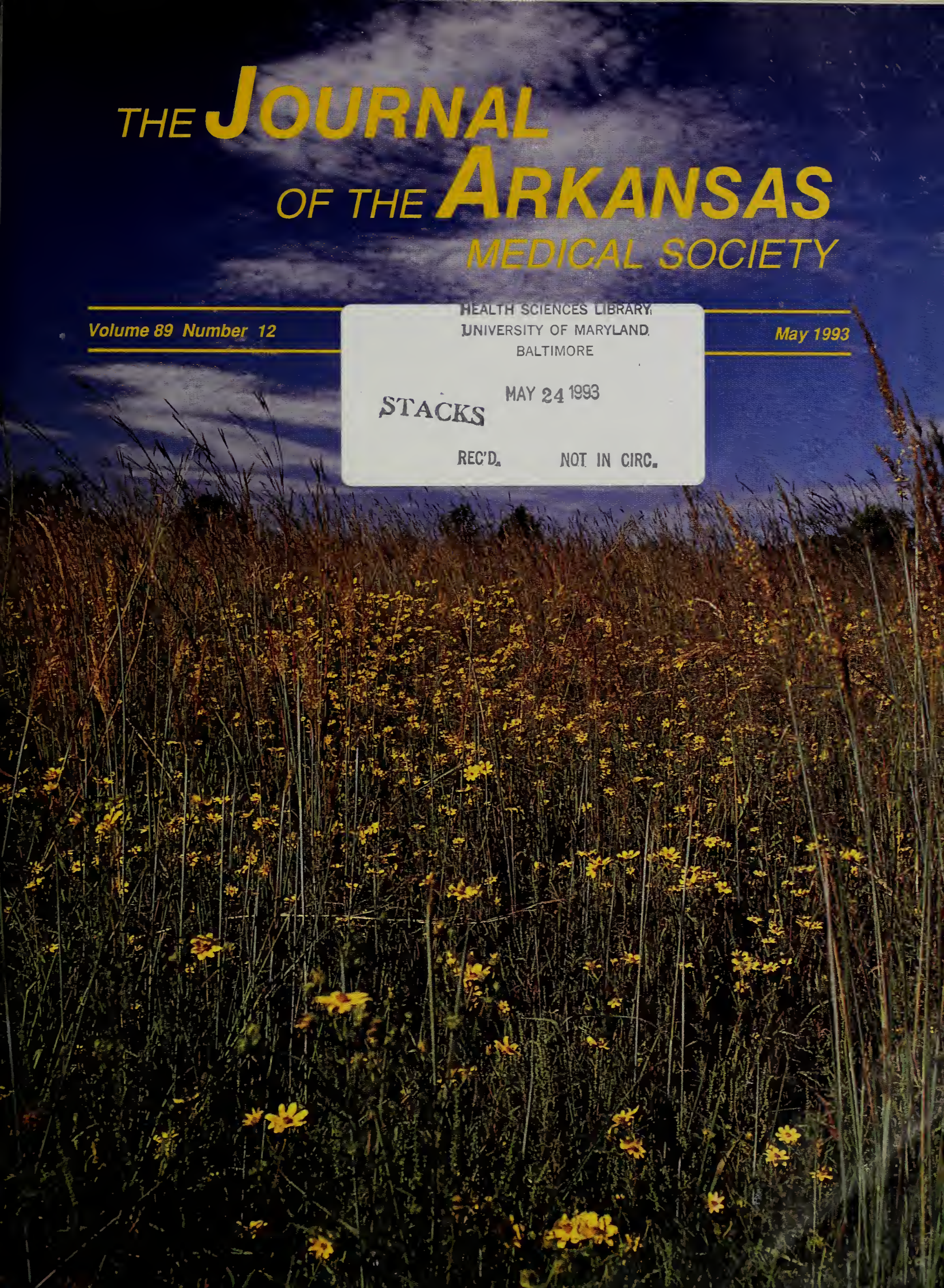

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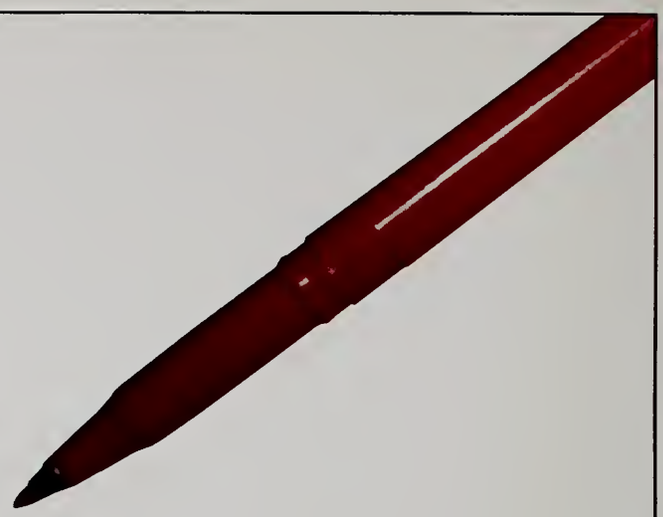

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Postoperative Ischemia After Cocaine Ingestion

Raeford E. Brown, Jr., M.D.*
Roberta Galford, M.D.**

ABSTRACT

Cocaine use has reached epidemic proportions in the United States. Patients may present having ingested cocaine for elective or emergent operative procedures. We report a case of acute myocardial ischemia in a young healthy male patient.

INTRODUCTION

The illicit use of cocaine has increased dramatically in the United States over the past two decades. It is now estimated that between five and ten million people use this drug on a regular basis.[1] The number of patients seen in hospitals who have used cocaine has also increased, primarily due to violent crimes often associated with drug use or drug trafficking. Adverse effects of cocaine include myocardial infarction, coronary vasospasm, arrhythmias, cardiomyopathies, seizures, and sudden death.[1-3] We describe a previously healthy male who presented for emergency surgery after ingesting cocaine who postoperatively demonstrated electrocardiographic (EKG) and echocardiographic evidence of an anterior wall myocardial infarction and acute ischemia.

CASE REPORT

A thirty-five year old, 80 kg black male was brought to the Emergency Department with a gun shot wound to his right buttocks. His vital signs were stable on admission with a blood pressure of 152/92 mmHg and a heart rate of 54 beats/minute. He was awake and conversant but acutely intoxicated with alcohol (ETOH 220 mg/dl). Shortly after admission, his blood pressure dropped to 80/40 mmHg with a pulse of 62 beats/minute. He was easily resuscitated with Lactated Ringer's and two units of packed red cells. The patient was scheduled for an emergency irrigation and debridement of his buttocks and an exploratory laparotomy. He denied any previous medical problems but admitted that he may have used crack on the night of admission. Cardiac risk factors consisted of a positive family history and cigarette smoking.

The patient was taken to the operating room; routine monitors and a radial arterial line were placed. Anesthesia was induced with ketamine 150 mg, succinylcholine 100 mg, and fentanyl 250 mcg using a rapid sequence technique. Endotracheal intubation was easily performed and the induction was well tolerated by the patient. Anesthesia was maintained with isoflurane 0.4 to 1.0% inspired concentration, pancuronium, and an additional 250 mcg of fentanyl during the case. Hemodynamic parameters were stable throughout the procedure, although four units of packed red blood cells were given to maintain a hematocrit greater than 28%. Throughout surgery, his EKG showed normal sinus rhythm without ectopy or ST and T wave changes. Emergence was uneventful, the patient's trachea was extubated, and he was taken to the Post Anesthesia Care Unit (PACU).

Thirty minutes after arrival in the PACU, the EKG tracing abruptly changed to T wave inversion with frequent unifocal premature ventricular beats. The patient's blood pressure and pulse were unchanged; pulse oximetry showed an oxygen saturation of 99%. Lidocaine 100 mg was administered and a nitroglycerine infusion was begun at 25 mcg/min. Serum potassium was 3.8 mEq/l. The patient denied chest pain or dyspnea. He did complain of incision pain, which was treated with morphine sulfate in 2 mg increments. A 12-lead EKG revealed ST segment elevation in leads V1 and

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V2 and inverted T waves in V3 to V6 with poor R wave progression. No preoperative EKG was available for comparison. An echocardiogram revealed an enlarged left ventricle, anteroseptal and apical akinesis with an estimated ejection fraction of 40%. On further questioning, the patient admitted to both intravenous and intranasal cocaine use on the night of his injury. Urine drug screen later confirmed the presence of cocaine and marijuana.

The patient was taken to the Intensive Care Unit on a nitroglycerine infusion. His postoperative course was uneventful. CPK-MB enzyme fractions peaked a 1.7% with a maximum absolute value of 39 U/Liter. Follow-up EKG's and echocardiogram performed twelve days later were unchanged. Based on these findings, EKG changes were felt to be consistent with perioperative ischemia secondary to cocaine use. The exact time of his myocardial injury, however, was indeterminate.

DISCUSSION

Evaluation by twelve-lead EKG and echocardiogram revealed evidence of severe ischemia or infarction. The patient did not complain of chest pain. In fact, lack of chest pain with postoperative ischemia is common and may relate to the presence of systemic narcotics, the presence of other painful stimuli, or the concurrent use of regional anesthesia. Creatine phosphokinase (CPK) levels as well as MB fractions of this enzyme were evaluated and did not meet criteria for acute myocardial infarction. This test, however, is relatively insensitive in trauma patients since the relationship between the MB fraction and the total CPK may be obscured in patients who have sustained significant muscle injury. In this patient, as in other trauma victims, clinical correlation is required for the diagnosis of acute myocardial infarction.

Cocaine is a naturally occurring alkaloid derived from the leaves of Erythroxylon coca, a tree indigenous to the Andes mountains of Peru and Bolivia. It was used for centuries by Inca Indians for its stimulant effect. In 1884, after its local anesthetic properties were discovered, Carl Koller pioneered the use of cocaine as a topical anesthetic for ophthalmological surgery.[4] Cocaine exerts its local anesthetic effects by preventing the rapid increase in membrane permeability to sodium ions during depolarization, thereby interrupting both the initiation and conduction of impulses in peripheral nerves.

Cocaine, an ester of benzoic acid, is highly lipid soluble. It is readily absorbed for all sites of application, including mucous membranes and the vascular beds of the lungs. Absorption through mucous membranes is slow, but allows for prolonged effect of the drug (up to 1.5 hours). In contrast, when cocaine is smoked or given intravenously, the effect is immediate (15-60 seconds) but last only 20 minutes.[5] It is rapidly metabolized by plasma and liver cholinesterases, with an in vitro half-life in the plasma of 30 minutes.[6] In individuals with pseudocholinesterase deficiency (e.g., liver disease), the effects may be prolonged.[4] Cocaine's metabolites, which are nontoxic, may be present in the urine for up to one week after ingestion.

Three forms of cocaine are currently available for recreational use: (1) cocaine hydrochloride, prepared by dissolving the alkaloid in hydrochloric acid to form a water-soluble salt, (2) "free-base", a relatively pure alkaloid produced by a dangerous extraction process using ether, and (3) crack, easily made by mixing cocaine with baking soda and water. Crack cocaine is a less pure form of the alkaloid, but is safer to produce. Both crack and free-base cocaine melt at lower temperatures than cocaine HCl and are heat-stable, making them available to be smoked.[4,5]

Particularly when compared to opiates, cocaine was once thought to have little addictive potential. Time has proven, however, that its addictive potential in humans has been underestimated. A compelling experimental study confirms the magnitude of this problem. Rats were allowed unlimited access to intravenous heroin or cocaine. Those rats self-administering heroin maintained normal grooming behavior and body weight; their 30-day mortality rate was 36%. Rats administering cocaine quickly ceased grooming behavior, lost weight, and had a 30-day mortality rate of 90%. In addition, several animals in the cocaine group had tonic-clonic seizures during testing, but resumed dosing once the convulsions terminated.[7]

The toxic effects of cocaine are produced by blocking the active transport of norepinephrine (NE) from extracellular fluid to the nerve terminal. The euphoric effects seem to be related to the impairment of dopamine reuptake in the central nervous system. This acute accumulation of dopamine leads to a sense of well-being.[8] After chronic use, however, the nerve terminals become depleted of dopamine; the "dopamine depletion hypothesis" states that this reduction may contribute to the dysphoria that develops during withdrawal and the inevitable craving for the drug.[9]

The major toxic effects of cocaine appear to be related to its effect on NE uptake. Since reuptake is the major route of clearance, blocking it results in an accumulation of norepinephrine at the adrenergic receptor. Organs that are sympathetically innervated (e.g., heart and blood vessels) are overstimulated, leading to tachycardia, hypertension, seizures, and hyperpyrexia.

In the past decade, cocaine has been linked to a variety of cardiovascular disorders, including myocardial infarction and ischemia, arrhythmias, and cardiomyopathy. This association remains temporal rather than causal in nature for several reasons. First, most available information is based on case reports. Second, the amount of cocaine used, its purity, and the

length of time between drug administration and the cardiac event is rarely known. The purity of street cocaine varies form 25 to 90 percent, and the drug is usually mixed with other compounds, including lidocaine, phencyclidine, antihistamines, and amphetamines. Finally, as in our patient, there is a high frequency of other drug use (e.g., alcohol or marijuana), making interpretation of the effects of cocaine alone difficult.[5]

Myocardial infarction and ischemia constitute the largest number of cardiovascular disorders related to cocaine abuse, though the first case was reported only in 1982.[10] In the majority of cases, the patients are young and male, with few cardiac risk factors other than cigarette smoking. In a review of 19 cases of myocardial infarction, all common routes of cocaine administration were used.[11] The pathogenesis of these events may be related to several factors, including alterations in hemodynamics, coronary vasospasm, accelerated atherosclerosis, and altered platelet function.[4]

Systemic hemodynamics can be significantly altered by cocaine.[4,5,8] Although small doses may produce sinus bradycardia by central vagal stimulation, larger doses produce an increase in heart rate by affecting the central and peripheral nervous systems. Systemic blood pressure increases secondary to vasoconstriction and sympathetically mediated tachycardia. In patients with established coronary artery disease, an increase in oxygen demand in the presence of fixed supply may precipitate ischemia and infarction. However, this mechanism does not explain infarction in patients with angiographically normal coronary arteries.

Cocaine may lead to an alteration in coronary vascular tone. Vasospasm may be the precipitating event in cocaine-induced infarction in patients with normal coronary arteries, similar to patients who have vasospastic, or Prinzmetal's angina.[8] It also may be a contributing factor in individuals with underlying atherosclerotic coronary artery disease.

The possibility of altered vascular tone is supported by a recent study by Lange et al.[12] In this study, 45 patients underwent cardiac catheterization for the evaluation of chest pain. Heart rate, blood pressure, coronary sinus blood flow, and left coronary artery dimensions were measured before and fifteen minutes after intranasal administration of saline or cocaine (2 mg/kg). (This dose of cocaine is often used in nasal surgery and is a much smaller dose than that associated with recreational cocaine use). No hemodynamic changes were seen after saline. However, after cocaine was given, heart rate and blood pressure increased, coronary sinus blood flow fell by 17%, coronary vascular resistance rose by 33%, and the diameter of the left coronary artery decreased by 8 to 12%. The cocaine-induced decrease in coronary sinus blood flow was prevented by pretreatment with the alpha-adrenergic blocking agent phentolamine. Therefore, it appears that coronary vasoconstriction is mediated by alpha-adrenergic receptors in the coronary arteries.

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Accelerated atherosclerosis may be another contributor to early myocardial infarction. In a series of 22 autopsies on cocaine addicts with a mean age of 32 years, Dressler et al found the frequency of severe coronary artery narrowing to be considerably greater than expected for that age group.[13] They concluded that either atherosclerosis is accelerated in cocaine addicts for unknown reasons or that cocaine provides a fatal stress in patients with premature coronary artery disease.

A fourth possible mechanism is an alteration of vascular endothelium and platelet function. It has been postulated that cocaine-induced vasospasm, secondary to decreased norepinephrine uptake, may lead to endothelial disruption at the site of an atherosclerotic plaque, serving as a nidus for platelet aggregation and subsequent thrombus formation.[4,8] In patients with normal coronary arteries, a combination of enhanced platelet aggregation and decreased endothelial prostacyclin production may predispose to coronary thrombus formation, either alone or in conjunction with vasospasm. This condition has been demonstrated in vitro, but not in vivo.[4]

In 1986, Isner et al published a review of 26 patients who experienced a variety of cardiac events (infarction, ventricular tachycardia or fibrillation, myocarditis, sudden death, or a combination of these) after recreational cocaine use.[1] Their analysis indicted four findings. First, cardiac complications were not unique to intravenous administration of cocaine; in fact, most patients had used cocaine intranasally. Second, seizure activity was not a prerequisite; it was observed in only two patients. Third, underlying coronary artery disease was not a requirement for a major cardiac event; five of the patients studied had normal coronary angiograms. (In addition, all five had negative ergonovine maleate studies; however, it is known that negative studies do not exclude vasospasm as the underlying cause). Finally, cardiac complications were not limited to massive overdoses of the drug. A subsequent literature review, performed in 1989, supports the above conclusions.[8] In a review of 34 myocardial infarctions, 9 of the 22 patients who had undergone cardiac catheterization had normal coronary arteries, and 24 or 34 had used cocaine intranasally. It is interesting to note that in this review, the time from cocaine use to infarction ranged from minutes to hours.

Two other significant cardiac complications of cocaine abuse are arrhythmias and cardiomyopathy. Arrhythmia secondary to cocaine use was first reported in 1947, after a patient developed ventricular tachycardia following intranasal cocaine for nasal surgery.[14] These conduction disturbances may be due to massive sympathetic discharge alone or in combination with contraction band necrosis. Myocardial contraction bands have been observed in more than 90% of cocaine-related deaths, and may provide a pathway for re-entrant arrhythmias, which may lead to sudden death.

Others contend that the primary disturbances in sudden death are not arrhythmias but are hyperthermia, seizures, and acidosis. In studies done on conscious dogs, Catravas et al found that a continuous infusion of cocaine led to generalized seizures, hypotension, and respiratory arrest with no arrhythmias observed.[15] Pretreatment of the animals with measures to prevent seizures (diazepam) or hyperthermia (decreased ambient temperature) were effective in preventing death. Pretreatment with propranolol attenuated the cardiovascular changes; however, all the animals had seizures and died. In humans, seizures often produce both metabolic and respiratory acidosis; acidosis is known to potentiate the effects of catecholamines on cardiac conduction and therefore may lead to arrhythmias if the seizure is not aborted. One case report supports this finding, as the patient's idioventricular rhythm was abolished only after he was treated with diazepam to control seizure activity and sodium bicarbonate to correct acidosis.[16] No studies, however, on the arrhythmogenic potential of cocaine in humans have been done.

The third cardiac complication is cardiomyopathy. In 1989, Chokshi et al reported a 35 year-old woman who developed seizures following a day-long bout of smoking cocaine.[3] An echocardiogram revealed diffuse left ventricular hypokinesis, with an ejection fraction of 10%; her electrocardiogram and endomyocardial biopsies were essentially normal. On day 14, after supportive therapy, a repeat ejection fraction was 49%. The similarity between this condition and catecholamine cardiomyopathy seen in patients with pheochromocytomas was noted.[17] Other cases reports suggest this association, but none are definitive.[18-20]

In summary, our evaluation of this patient and the literature relevant to cocaine use in our society leads us to conclude that cocaine use and abuse are common and may predispose to cardiac events in patients with no other significant medical history. Perioperative cocaine use may produce ischemia or infarction in healthy individuals by thrombosis or vasospasm; cardiac arrhythmias are also common. These cardiac events may be relatively asymptomatic because of the superimposition of pain, narcotics, and regional anesthetic techniques in the perioperative patient. The event may occur hours after the ingestion or inhalation of the drug. Trauma victims in whom drug abuse is suspected should have an electrocardiogram prior to surgery.

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REFERENCES

1. Isner JM, Estes NAM, Thompson PD, et al. Acute cardiac events temporally related to cocaine abuse. N Engl J Med 1986;315:1438-43
2. Ascher EK, Stauffer JCE, Gaasch WH. Coronary artery spasm, cardiac arrest, transient electrocardiographic Q waves and stunned myocardium in cocaine-associated acute myocardial infarction. Am J Cardiol 1988;61:939-41
3. Chokshi SK, Moore R, Pandian NG, Isner JM. Reversible cardiomyopathy associated with cocaine intoxication. Ann Intern Med 1989;111:1039-40

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4. Loper KA. Clinical toxicology of cocaine. Med Toxicol Adverse Drug Exp 1989;4:174-85
5. Cregler LL, Mark H. Medical complications of cocaine abuse. N Engl J Med 1986;315:1495-1500
6. Byck R, Jatlow P, Barash P, Van Kyke C. Cocaine: Blood levels, excretion, and physiological effect after intranasal application in man. Psychopharmacol Bull 1976;12:47-8
7. Bozarth MA, Wise RA. Toxicity associated with long-term intravenous heroin and cocaine self-administration in the rat. JAMA 1985;254:81-3
8. VanDette JM, Cornish LA. Medical complications of illicit cocaine use. Clin Pharm 1989;8:401-11
9. Dackis CA, Gold MS. New concepts in cocaine addition: the dopamine depletion hypothesis. Neurosci Biobehav Rev 1985;9:469-77
10. Coleman DL, Ross TF, Naughton JL. Myocardial ischemia and infarction related to recreational cocaine use. West J Med 1982;136:444-6
11. Kossowsky WA, Lyon AF, Chou SY. Acute non-Q wave cocaine-related myocardial infarction. Chest 1989;96:617-21
12. Lange RA, Cigarroa RC, Yancy CW Jr, et al. Cocaine-induced coronary-artery vasoconstriction. N Engl J Med 1989;321:1557-62
13. Dressler FA, Malekzadeh S, Roberts WC. Quantitative analysis of amounts of coronary arterial narrowing in cocaine addicts. Am J Cardiol 1990;65:303-8
14. Young D, Glauber JJ. Electrocardiographic changes resulting from acute cocaine intoxication. Am Heart J 1947;34:272-9
15. Catravas JD, Waters IW. Acute cocaine intoxication in the conscious dog: studies on the mechanism of lethality. J Pharmacol Exp Ther 1981;217:350-6
16. Jonsson S, O'Meara M, Young JB. Acute cocaine poisoning. Importance of treating seizures and acidosis. Am J Med 1983;75:1061-4
17. Garcia R, Jennings JM. Pheochromocytoma masquerading as a cardiomyopathy. Am J Cardiol 1972;29:568-71
18. Gradman AH. Cardiac effects of cocaine: a review. Yale J Biol Med 1988;61:137-47
19. Wiener RS, Lockhart JT, Schwartz RG. Dilated cardiomyopathy and cocaine abuse. Report of two cases. Am J Med 1986;81:699-701
20. Duell PB. Chronic cocaine abuse and dilated cardiomyopathy (letter). Am J Med 1987;83:601

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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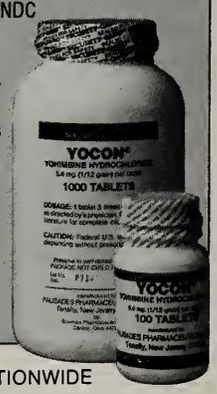

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Case Management

Jewelyn D. Bradshaw, R.N., B.A.*
Robert B. Benafield, M.D.**

Over the last few years, health care costs have soared, technology has developed more rapidly than ever before and service companies (e.g., home infusion, home health and equipment agencies) have quadrupled. These factors, among others, have left the physician and patient in a maze, maneuvering through the health care system. The emerging solution for assistance to the physician and his patient has been the case manager.

Case management may be defined as a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost effective outcomes.[1] This definition is applied to any diagnosis generally defined as highly complex, able to be managed by a physician in an alternative setting (rather than the hospital), and costly (e.g., premature infants, respiratory dependent patients and AIDS patients). Intervention and coordination is based on the opportunity to achieve high quality care and cost effectiveness for the services delivered.

The role of the case manager is diverse: communicator (between patient, family, physician, agencies and insurance company), advocate, negotiator, and coordinator of services. The case manager works with the physician coordinating, negotiating, and monitoring the quality of care a patient receives from the agencies, basing the care received on the orders of the physician.

Before a hospital discharge, case managers are often called upon to assist the physician. They assess agencies, insurance coverage and patients' home environment. The home and family environment must be found suitable and adaptable to be able to continue to provide the level of quality care administered in the hospital.

The following two cases represent examples of case management and the cost differential one can achieve.

CASE STUDIES IN CASE MANAGEMENT

CASE STUDY A - Complex Case

Mr. B is a 52 year-old male, C2 quadriplegic ventilator dependent patient, since an automobile accident in 1990. He has spent eights months in a CCU and rehabilitation hospital. Physician and family requested assistance from a case manager to assist with assessing, coordinating and negotiating for Mr. B to be placed at home as an alternative to hospitalization.

This complex case required:

- 24-hour nursing (RN and LPN)
- Ventilator with all supplies
- Durable medical equipment: bed, specialized wheelchair, suction and percussion machine, etc.
- Drugs
- Respiratory therapist, medical social worker
- Multiple supplies: urinary catheters, trach kits, gloves, syringes, dressings, etc...

His home was adapted to his medical needs, and a van remodeled to transport Mr. B. His outcome has had a positive effect on his physical and mental status. The opportunity to remain at home and continue to go to his business, has allowed him a semi-normal life.

HOSPITAL COST	-VS-	HOME CARE COST
$2,135.00/day		$849.00/day

* Ms. Bradshaw is the Programs Coordinator for Arkansas Blue Cross and Blue Shield's Health Benefits Management Division.

** Dr. Benafield, who recently retired from Arkansas Blue Cross and Blue Shield, serves as a consultant to the Company's Health Benefits Management Division.

CASE STUDY B

Mrs. P is a 52 year-old diabetic diagnosed with cellulitis of the right foot with ascending inflammation. She had previously been hospitalized for cellulitis and was treated routinely with I.V. antibiotics and debridement. Mrs. P was discharged home on antibiotics by mouth and returned seven days later to her physician. On this office visit it was determined Mrs. P wasn't healing properly and the physician wanted a regimen of I.V. Gentamycin 80 mg every eight hours, with twice daily Betadine soaks and dressing changes. As an alternative to hospitalization, the physician requested the above orders be followed at home.

The approximate length of therapy was to be three weeks. Mrs. P was to be instructed and assisted with her home care through the hospital based home health agency and I.V. company.

HOSPITAL COST	-VS-	HOME CARE COST
$1,173.00/day		$307.00/day

As the above case studies indicate, there may be significant advantages with case management:

- The patient's quality of life is improved and the attainment of normalcy is approximated.
- Many patients benefit from a less stressful environment, which may speed recovery.
- Shorter hospitalization can be less of a strain for family members.
- By conserving insurance benefits for large and complex cases, individuals can increase the time of coverage.

In summary, it appears that case management will continue to expand. Hopefully, the physician community will help guide this dynamic process. By working with physicians throughout the state, Arkansas Blue Cross and Blue Shield was able to save our policyholders $9.3 million in 1992.

References

1. Certification Manual for Case Managers, 1992.
2. Donnamarie, Ugan, "Case Management Services: Third-Party Providers and Catastrophic Care Services", MEDICAL INTERFACE, p.p. 50-52, March 1990.

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Can Defense Lawyers Still Talk to Treating Physicians About Patient Information?

Rob W. Wright*
Michael W. Mitchell, J.D.**

In a medical malpractice case in Arkansas federal court, a defense attorney was sanctioned $5,000. The court found that the attorney was in violation of Rule 35 of the Arkansas Rules of Civil Procedure, which concerns the obtaining of medical information from treating physicians.

The issue concerned the discovery by attorneys of the results of physical and mental examinations of a plaintiff. Rule 35, which was effective July 1, 1991, prohibits informal discovery or "*ex parte*" communication between the plaintiff's physician and the defendant's attorney. Prior to the enactment of Rule 35, defense counsel was not prohibited from communicating with a plaintiff's treating physician on an informal basis. Currently the rule is as follows:

Where a party relies upon his physical, mental, or emotional condition as an element of his claim or defense, he shall, upon the request of any other party, execute an authorization to allow such other party to obtain copies of his medical records; provided, however, a party shall not be required, by order of court or otherwise, to authorize any communication with his physician or psychotherapist other than (1) the furnishing of medical records, and (2) communications in the context of formal discovery procedures.

The impetus for this amendment was the decision in ***Duncan v. Cole,*** 786 S.W.2d 587 (Ark. 1990). In ***Duncan,*** the Arkansas Supreme Court refused to issue a writ of prohibition requested by the defense. The writ would have prevented the enforcement of a lower court order prohibiting any contact by the defense attorney with the plaintiff's treating physicians without the attorneys for the plaintiff being present. Arkansas Rule of Civil Procedure 35 (c) is the result of this opinion.

The rationale given for adopting the amendment to Rule 35 is that it provides necessary safeguards for the protection of the confidential relationship between a plaintiff and his physician. The danger of an *ex parte* interview is that it may result in disclosure of irrelevant, privileged medical information. ***Loudon v. Mhyre,*** 756 P.2d 138 (Wash. 1988). The reasoning behind the Rule is that the protection can be afforded by allowing plaintiff's counsel an opportunity to participate in physician interviews in order to raise appropriate objections. ***Id.*** The mere threat that a physician might engage in private interviews with defense counsel would have a chilling effect on the physician-patient relationship and hinder further treatment. ***Id.*** The presence of the plaintiff's counsel as the protector of a patient's confidences will allay the fear that irrelevant confidential material will be disclosed and preserve the fiduciary trust relationship between physician and patient. ***Wenninger v. Muesing,*** 240 N.W.2d 333 (Minn. 1976).

Additionally, a physician has an interest in avoiding inadvertent wrongful disclosures during *ex parte* interviews. A cause of action may lie against the physician for authorized disclosure of privileged information. *See generally,* 20 A.L.R.3d 1109 (1968). The participation of the plaintiff's counsel also protects the physician in this regard. Furthermore, permitting *ex parte* communications could result in disputes at trial should a doctor's testimony differ from the informal statements given to the defense counsel, and may require defense counsel to testify as an impeachment witness. ***Loudon*** at 141. Finally, there exists the potential that defense counsel may seek to improperly influence plaintiff's treating physician, especially if the treating physician and the defendant are covered by the same insurance carrier.

Courts holding that defendant's counsel may conduct *ex parte* interviews with the plaintiff's treating

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** Michael Mitchell is a partner in the Mitchell, Blackstock, Simmons & Barnes Law Firm in Little Rock, and is legal counsel to the Arkansas Medical Society.

physician have offered several rationales. These include decreased litigation costs, the potential to eliminate nonessential witnesses, *Green v. Bloodsworth*, 501 A.2d 1257 (Del. Super. 1985), early evaluation and settlement of claims, *Trans-World Investments v. Drobny*, 554 P.2d 1148, 1152 (Al. Super. 1976), easier scheduling of interviews compared to depositions, and more candor in the interview than in depositions. Furthermore, these courts reason that requiring the use of formal discovery would allow plaintiff's counsel to monitor the progress of the defense while plaintiff's case would not be under such scrutiny. *Doe v. Eli Lilly & Co., Inc.*, 99 F.R.D. 126 (1983).

The statutes from some of our surrounding states (Oklahoma, Tennessee, Texas, Missouri and Mississippi) do not have any provision covering *ex parte* interviews. However, Louisiana makes a partial reference to this issue by stating that "whenever a mental or physical condition is in controversy, medical records are discoverable through formal discovery methods". La. Rev. Stat. Ann. § 44:7 (c) (West 1982).

CONCLUSION

Physicians in Arkansas will definitely see the effect of Rule 35. Rather than informal and private conferences with defense counsel, physicians of plaintiffs in lawsuits will be asked to supply records and then see defense counsel only with court reporters present as well as plaintiff's counsel present.

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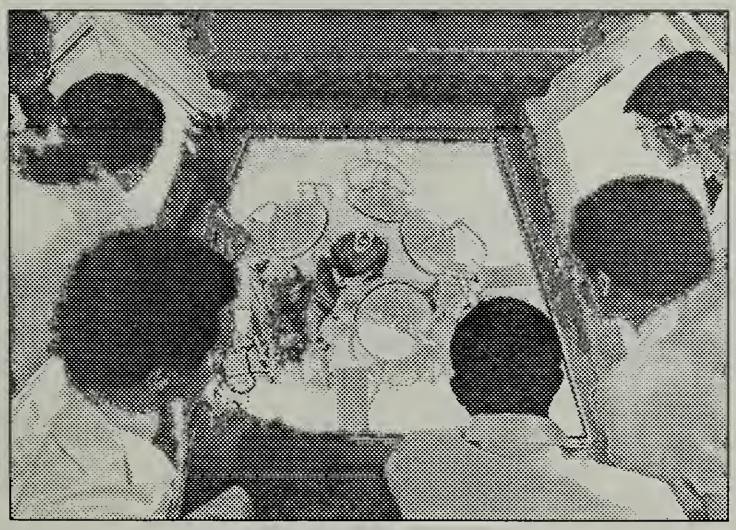

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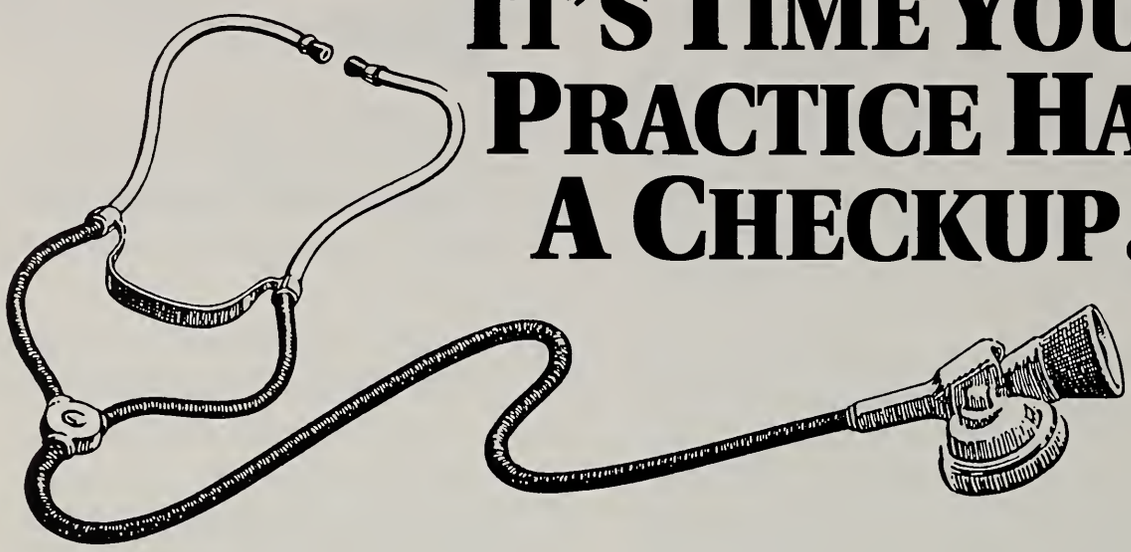

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An Update of Solid Organ Transplantation at UAMS

Gary W. Barone, M.D.*
Beverley L. Ketel, M.D.**
H. Gareth Tobler, M.D.***

ABSTRACT

The one year survival for solid organ transplants is 70 to 90%. Encouraged by this success, the University of Arkansas for Medical Sciences is expanding its organ transplant center and will offer renal, pancreas, liver, heart, and lung within a year. The limiting factor in transplants continues to be a shortage of Donor organs and the need for increased referral of potential donors.

INTRODUCTION

With both the introduction of cyclosporine A (Sandimunne: Sandoz) in 1983 and the development of improved techniques for donor organ procurement and preservation, extra-renal (pancreas, liver, heart, lung) transplantation has become a viable treatment for many endstage patients. In 1989, national data for transplantation showed that one year graft survival for pancreas transplants was 75%, liver 70%, heart 92%, and lung 75%. In 1990, 5,573 extra-renal organ transplants were performed, and this increased to 6,060 in 1991. The Department of Surgery at the University of Arkansas for Medical Sciences (UAMS) has had a renal transplant program for many years. In order to provide the people of Arkansas access to the now highly successful extra-renal organ transplants, the Department of Surgery has recently expanded its transplant program to include pancreas, heart and lung transplants. Dr. Beverley Ketel became head of the Division of Transplantation in January, 1991, and was joined by Dr. Gary Barone in July, 1991. Together Drs. Ketel and Barone began a pancreas transplant program in 1991 and are working towards a liver transplant program. Dr. H. Gareth Tobler, a cardiothoracic surgeon who trained at Stanford University has started a heart and lung transplant program at UAMS.

RENAL TRANSPLANTATION

The University of Arkansas has a long and successful history of renal transplantation, being the sixth medical center in the United States to offer the treatment when its program began in 1964. As graft success has improved and patient mortality has dropped, renal transplantation has become the therapy of choice for many more patients with endstage renal disease. Up to 30% of dialysis patients are suitable candidates for transplantation but shortage of donated organs severely limits the number of transplants performed. In 1991, 45 isolated kidney transplants were performed at UAMS (16 living related and 29 cadaveric). One year patient and graft survival were 95% and 88% respectively. Renal transplant recipients receive a combination of prednisone, cyclosporine and azathioprine for immunosuppression. Cardiovascular disease has replaced infection as the most common cause of death in the first year after renal transplantation with rejection remaining the most common cause of graft loss.

PANCREAS TRANSPLANTATION

In July, 1991, the first pancreas transplant was performed at UAMS and, in the first year, 10 were performed (Figure 1). Pancreas transplantation is presently the only known cure for insulin dependent juvenile-onset diabetes mellitus by restoring normal glucose metabolism with no dietary restrictions nor the need for exogenous insulin. Pancreas transplantation is most commonly performed in combination with kidney transplantation in diabetic patients with renal failure because acute rejection is difficult to diagnose in an isolated pancreas graft. When performed simultaneously with a

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Figure 1: Whole Pancreas Graft (arrow: duodenal segment, double arrow: spleen.)

kidney from the same cadaver donor, the kidney serves as the indicator of rejection. All 10 recipients at UAMS have received combined kidney-pancreas transplants. Patients undergoing combined kidney-pancreas transplants receive higher doses of prednisone, cyclosporine and azathioprine than do kidney transplant recipients. Nevertheless, rejection is a more common problem and pancreas graft survival is about 10 percentage points less than kidney graft survival at one year. Patient survival is not different between kidney-pancreas and kidney alone recipients.

At UAMS, 9 of 10 kidney-pancreas transplant recipients are alive. One patient died from a massive CVA two months post-transplant. Seven of 10 patients have normal function in the pancreas graft and 8 of 10 patients have normal function in the kidney transplant.

As with a kidney transplant, the pancreas graft is placed in the recipient's pelvis and blood supply is via the external iliac vessels. Reconstruction of the arterial supply of pancreas graft is necessary prior to transplantation. As shown in Figure 2, an arterial conduit composed of the donor's common, external and internal iliac arteries is used for arterial reconstruction of the superior mesenteric and splenic arteries from the pancreas graft.

Pancreas transplantation has been shown to halt progression of diabetic complications including retinopathy, neuropathy and nephropathy. It offers a good level of health for recipients but, as with kidney transplantation, lack of organ donors limits its availability.

LIVER TRANSPLANTATION

Liver transplantation is being developed at UAMS and the first liver transplant in Arkansas is expected in 1993. Success rates for the procedure are very good in both children and adults but it is perhaps the most demanding of all solid transplants. A brief list of indications for adult liver transplantation is included in Table I and for children in Table II. A realistic goal within the state of Arkansas is approximately 10-20 tranplants per year which should be supplied with livers procured from donors within the state.

HEART/LUNG TRANSPLANTATION

The Arkansas Heart Transplant Program was organized in April, 1991 to combine the heart transplant resources and expertise of Arkansas Children's Hospital, Baptist Medical Center and the University Hospital of Arkansas into a single coordinated program. It provides a unified approach and an opportunity for exchange of idea and education. In the first year, thirteen patients underwent transplant by physicians in the Arkansas Heart Transplant Program. This includes 4 children and 9 adults with 11 survivors ranging in age from 2 to 66. Heart transplant conferences are held every other week alternately at Arkansas Children's Hospital and Baptist Medical Center. These conferences are attended by cardiologists, cardiac surgeons, nurses, social workers, administrators, and representatives from ARORA. Participants at each of the hospitals have been pleased with the success of the program and expect continued growth and cooperation.

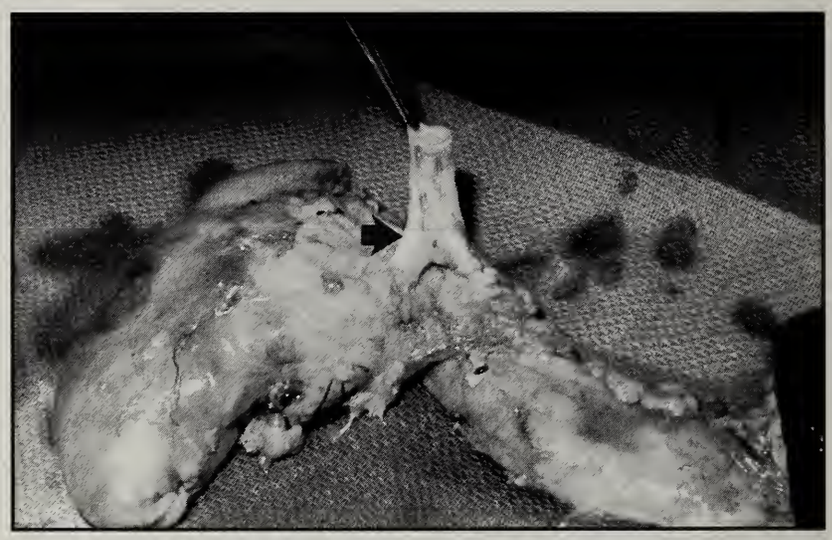


Figure 2: Arterial Reconstruction of Whole Pancreas Graft (arrow: donor arterial iliac graft.)

A program for lung transplantation at the University Hospital will be initiated by publication of this communication. Patients with end stage restrictive diseases: idiopathic pulmonary fibrosis and sarcidosis, and obstructive diseases: alpha$_1$-antitrypsin, non-bullous emphysema, primary pulmonary hypertension and selected cases of Eisenmenger's will be candidates for

single lung transplantation. Physicians interested in contributing to and participating in the lung transplant program are welcomed.

CONCLUSION

Hopefully, within the next year, all major forms of solid organ transplantation will be offered within the state of Arkansas and at UAMS. The survival for most solid organ transplants is very good with 70-90% survival at approximately one year. It is generally felt that, even though not perfect, rejection is not necessarily the major limiting factor in solid organ transplantation in Arkansas and the rest of the country is organ donation. About 20-30% of all patients waiting for either a heart or liver transplant die before ever being transplanted.[2] As transplant surgeons, we need to encourage more organ donation with increased referrals of potential organ donors. In general, all organs except for livers at the present remain within the state of Arkansas. It has been reported that only 25-50% of all potential donors within the state of Arkansas are identified and referred.[2] Any potential organ or tissue donor should be referred to ARORA (Arkansas Regional Organ Recovery Agency) at 1-800-443-7243. For any questions about organ transplantation, the UAMS Transplant Office can be reached at 1-800-552-8026.

TABLE I
INDICATIONS FOR ORTHOTOPIC LIVER TRANSPLANTS IN ADULTS

- Chronic active hepatitis (viral)
  - C (non-A/non-B)
  - B
  - A
- Primary biliary cirrhosis
- Primary sclerosing cholangitis
- Laennec's cirrhosis
- Neoplasms
- Metabolic disorders
- Autoimmune hepatitis
- Budd-Chiari syndrome
- Trauma

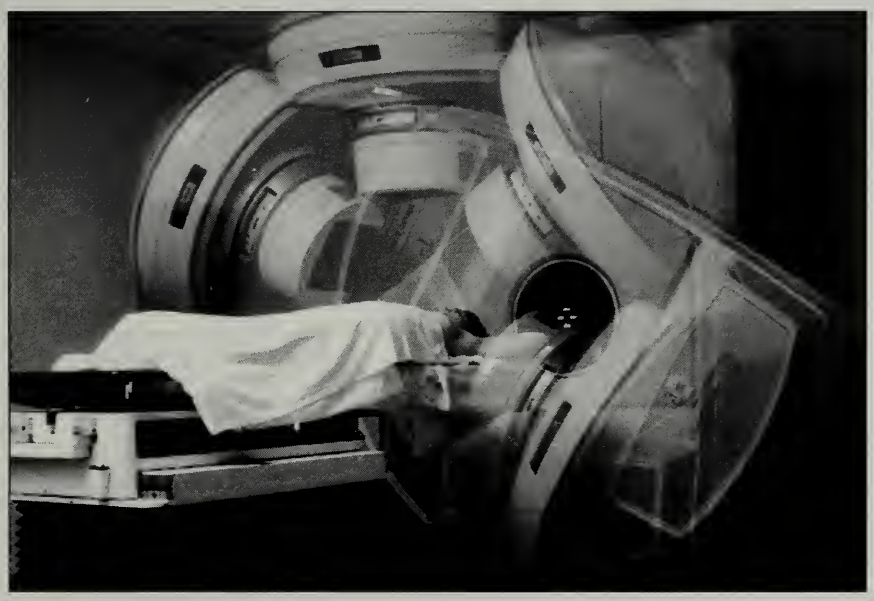
TABLE II
LIVER TRANSPLANT INDICATIONS IN CHILDREN

- Biliary atresia or hypoplasia
- Metabolic disorders
- Neonatal hepatitis
- Fulminant hepatitis
- Chronic active hepatitis
- Neoplasms
- Familial intrahepatic cholestasis

REFERENCES

1. United Network for Organ Sharing Statistics, Richmond, Virginia 23225.
2. Evans RW, Orians CE, Ascher NL. The Potential supply of organ donors. JAMA 267: 239-246, January 8, 1992.

Breast-Conservation Treatment



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Diagnosis and Treatment of Atraumatic Vascular Insufficiency of the Upper Extremity: Female Smoker's Syndrome

Joseph E. Sheppard, M.D.
David Tamas, M.D.
Michael M. Moore, M.D.
G. Thomas Frazier, M.D.
Edward R. Weber, M.D.
Richard W. Satre, M.D.

Abstract

A retrospective analysis of 30 angiograms in 29 patients performed at Doctor's Hospital since June of 1989 was carried out. Of these, 15 patients with 16 involved extremities presented with no antecedent trauma and significant symptoms of arterial insufficiency with impending digital necrosis. Eleven were female and four were male. Underlying medical problems included renal failure in four, diabetes in two, scleroderma in two and vasculitis in one. A unique group of six patients had no prior underlying medical problems. All six patients were female and all were smokers. A surprisingly high incidence of major arterial occlusion was noted. The radiographic features appeared distinct from the common causes of vascular insufficiency in the hand, that is, Raynaud's, thromboangiitis obliterans (Buerger's disease), and ulnar artery thrombosis from repetitive microtrauma (hypothenar hammer syndrome). This review is intended to discuss the evaluation and management of this group of patients.

Introduction

Digital ischemia in the upper extremity is most common following traumatic injuries to the forearm, wrist, hand and fingers, often accompanied by associated skeletal and soft tissue injuries.[1] On the other hand, chronic vascular insufficiency may be manifested by severe cold intolerance and pain, with or without tip ulceration or impending digital necrosis.[2]

Methods and Materials

Twenty-nine patients with 30 involved extremities underwent upper extremity arteriography to evaluate vascular insufficiency. Fourteen patients had a history of antecedent trauma: 6 with crush injuries; 3 with hypothenar hammer syndrome; 2 sharp lacerations; and 2 with blast injuries. Fifteen patients with no history of trauma underwent arteriography on 16 extremities. Four patients with chronic renal failure demonstrated diffuse peripheral disease. Three of these patients required amputations for complications related to vascular shunts performed for hemodialysis. Two patients had connective tissue disorders associated with vasculitis and one patient had vasculitis as an isolated finding. One arteriogram was normal. Six patients with no trauma or underlying medical illness had abnormal arteriograms of seven extremities. This group represents the focus of this analysis.

Results

The left hand was involved in two instances, and the right in five. All were females and all were active smokers. Table I demonstrates the presenting complaints.

Table I:

Patient Initials:	D.E.	J.P.	P.B.	L.P.	J.N.	C.T.(R)	C.T.(L)
Presenting Symptoms							
Pain	X	X	X	X	X	X	X
Paresthesiae		X	X				
Cold Intolerance	X		X	X		X	X
Color Changes							
Intermittent		X	X				X
Fixed	X				X	X	
Ulceration				X			
Gangrene	X				X	X	

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The differential diagnosis of atraumatic vasospasm and arterial occlusion is quite extensive and includes connective tissue diseases such as scleroderma,[3] CREST, lupus with vasculitis, rheumatoid vasculitis, primary Raynaud's phenomenon,[4] polyarteritis nodosa, giant cell arteritis, "hypothenar-hammer" syndrome,[5] thromboangiitis obliterans,[6] premature atherosclerotic disease from hyperlipidemia, thromboembolic phenomenon, subacute bacterial endocarditis, and other infectious endarteritis (such as virus, hepatitis, fungus, and candidemia).[7-9]

Preoperative studies performed on this group of six patients is shown in Table II. Although echocardiography was abnormal in two patients, the heart was felt not to be a source of emboli in these patients.

Table II:						
Patient Initials:	D.E.	J.P.	P.B.	L.P.	J.N.	C.T.(R&L)
Additional Studies						
Hemaglobin	13.6	13.4	14.6	11.5	14.3	15.5
Hematocrit	39.4	38.4	42.7	33.8	41.7	44.4
PT	Nml	Nml	Nml	Nml	ND	Nml
PTT	Nml	Nml	Nml	17.3	ND	Nml
ESR	ND	38	ND	65	ND	ND
Cryoglobulins	ND	Nml	Nml	Abnml	ND	ND
C3/C4 Complement	Nml	Nml	ND	Nml	ND	ND
SPE	Nml	Nml	Nml	ND	ND	ND
ANA	ND	Nml	Nml	Nml	ND	ND
RF	ND	Nml	Nml	+	ND	ND
Thyroid Fxn	Nml	Nml	ND	ND	ND	ND
Lyme Titer	ND	Nml	ND	ND	ND	ND
Cholesterol	ND	ND	ND	270	ND	ND
EMG/NCV	ND	Nml	Nml	ND	ND	Nml
Cardiac Echo	Nml	Abnml	Nml	ND	ND	Abnml

Nml=Normal, Abnml=Abnormal, ND=Not Done

A trial of medical management was used in four patients before embarking on arteriography. Nifedipine was the initial drug of choice, occasionally in combination with nitrol-lanolin ointment applied directly on the symptomatic digits, or a nitrol patch. Additional medicines used perioperatively are shown in Table III.

Table III:							
Patient Initials:	D.E.	J.P.	P.B.	L.P.	J.N.	C.T.(R)	C.T.(L)
Medical Management							
ASA		X		X	X		
Dipyridamole(Persantine)	X					X	X
Nifedipine (Procardia)		X	X	X		X	X
Nitrol Patch						X	X
Nitrol Ointment			X			X	X
Stellate Ganglion Block							X
Xanax						X	X
Heparin		X	X	X		X	X
Coumadin		X	X	X		X	X

Doppler pressures, digital temperatures, pulse oximetry and plethysmography are valuable, noninvasive tools which can be used in the early diagnosis of vascular insufficiency of the hand and digits. The inconsistent use of these modalities in this group precluded the inclusion of this data in this analysis. When medical management failed or the presenting symptoms warranted, arteriography was performed (Table IV).

Surgical or invasive angiographic intervention (angioplasty) was performed in four patients (Table V).

Discussion:

Occlusive Arterial Diseases of the upper extremity may be acute, related to emboli, thrombi, frostbite, coagulopathy, and/or drug injection; or chronic related to a variety of medical abnormalities.

One of the most common conditions resulting in chronic upper extremity ischaemia is Raynaud's Disease or Phenonomenon. Raynaud's description of "Local Asphyxia and Symmetrical Gangrene of the Extremities" in 1862 has evolved to include the use of "Raynaud's Phenomenon" to describe transient complaints of longstanding bilateral cold intolerance associated with discoloration which are usually reversible.[10] This review focuses on this patient group.

All patients with ulnar artery thrombosis through the Canal of Guyon near the hook of the hamate described as "Hypothenar Hammer Syndrome" were eliminated from the patient analysis. Also excluded were patients with known medical causes of vasculopathy. This report is not intended to be a review of the nonoperative management of Raynaud's Disease or Phenomenon. All patients were referred to the Arkansas Hand and Microsurgery Center after failed conservative diagnostic and therapeutic intervention, therefore, arteriography was performed to rule out surgically reversible disease. The findings of major vascular occlusion of a focal nature in four of the six patients was a surprisingly high incidence. Common to all were the facts that all were active smokers and all were female.

Three patients presented with fixed color changes indicative of gan-

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Table IV:							
Patient Initials:	D.E.	J.P.	P.B.	L.P.	J.N.	C.T.(R)	C.T.(L)
Angiographic Findings							
Brachial Artery Stenosis	X						
Radial Artery Occlusion		X		X		X	
Ulnar Artery Occlusion		X				X	
Incomplete Superficial Arch			X	X			
Digital Artery Occlusion(single)			X				X
Thromboangiitis Obliterans					X		

Table V:							
Patient Initials:	D.E.	J.P.	P.B.	L.P.	J.N.	C.T.(R)	C.T.(L)
Surgical Management			No	No			
Angioplasty	X						
Thrombectomy/Embolectomy							
Ulnar Artery		X					
Vein Graft							
Radial Artery		X				X	
Sympathectomy							
Common Digital						X	X
Proper Digital		X					
Amputation	Index				Index	Index	

grene. Although all three of these patients required index finger amputations, two patients had arterial lesions arnenable to angioplasty (D.E.) or vein grafting (Figure 2) and have had no further episodes of digital necrosis. The other patient (J.N.) had classic thromboangiitis obliterans angiographically, and successfully pursued a smoking cessation program.

One patient (L.P.) with a potentially reconstructible lesion declined surgery, and has remained stable with nicotine avoidance and anti-coagulation.

Undoubtedly, nicotine stimulation of the peripheral vascular system plays an integral role in the progression of the findings seen in the female patients presented in this paper. Although suitable for only two of the six patients evaluated in this study (Figure 1), common digital or digital sympathectomies may be used in reversible vasospasm shown to be responsive to stellate ganglion blocks.

When irreversible vascular occlusion treatable with microvascular surgery angioplasty are identified, these alternatives may be beneficial.

Four of six female smokers with Raynaud's phenomenon and upper extremity digital ischemia were found to have treatable major vessel occlusions of the distal upper extremity, hopefully, resulting in salvage of digits that might otherwise be lost to gangrene.

REFERENCES

1. Wilgis, E.F. Shaw, "Vascular Injuries and Diseases of the Upper Limb", c.1983.
2. Lewis, S.Thomas., "Vascular Disorders of the Limbs", c.1936.
3. O'Brien, B.McC., V.Kumar, P.A., Mellow, C.G., Oliver, T.V., "Radical Microarteriolysis in the Treatment of Vasospastic Disorders of the Hand, Especially Scleroderma", The Journal of Hand Surgery., Vol.17B., p.447-452, Aug.1992.
4. Duprez, D., De Buyzere, M., Vandenbroeck, P., De Meester, M., Lamon, M.C., Clement, D.L., "Examination of Raynaud's Phenomenon in Traumatic Vasopastic Disorders", Angiology-The Journal of Vascular Diseases, p.142-146., Feb.1992.
5. Harris, E. John Jr., Taylor, Lloyd M. Jr., Edwards, James M., Mills, Joseph L., Porter, John M., "Surgical Treatment of Distal Ulnar Artery Aneurysm", The American Journal of Surgery., Vol.159, p.527-530., May 1990.
6. Olin, Jeffery W., Young, Jess R., Graor, Robert A., Ruschhaupt, William F., Bartholomew, John R., "The Changing Clinical Spectrum of Thromboangiitis Obliterans(Buerger's Disease)", Supplement IV Circulation., Vol.82, No.5, Nov.1990.
7. Kadwa, A.M., Robbs, J.V., "Gangrenous Fingers: The Tip of the Iceberg", J.R. Coll. Surg. Ebinb., Vol.35, p.71-74., April 1990.

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8. Koman, L. Andrew., Urbaniak, James R., "Ulnar Artery Thrombosis", Hand Clinics-Symposium on Microvascular Surgery., Vol.1, No.2, p.311-325., May 1985.
9. Allen, Judith A., Devlin, Mark A., McGrann, Sean., Doherty, Ciaran C., "An Objective Test For the Diagnosis and Grading of Vasospasm in Patients with Raynaud's Syndrome", Clinical Science., p.529-534., Jan.1992.
10. Wilgis, E.F. Shaw, "Vascular Disorders", Hand Clinics., Vol.9, No.2. Feb.1993.

Authors: Dr. Joseph E. Sheppard, Dr. Michael M. Moore, Dr. G. Thomas Frazier and Dr. Edward R. Weber are associated with the Arkansas Hand and Microsurgery Center, Little Rock. Dr. David Tamas and Dr. Richard W. Satre are associated with Radiology Associates, Doctor's Hospital.

1A.

1B.

Figure 1: (J.P.) 49 yowf smoker with severe left hand ischemia. a) Initial and b) delayed views demonstrate occlusion of the radial palmar arches and the distal ulnar artery (arrows). Patient underwent thrombectomy and digital sympathectomy with good results.

2A.

2B.

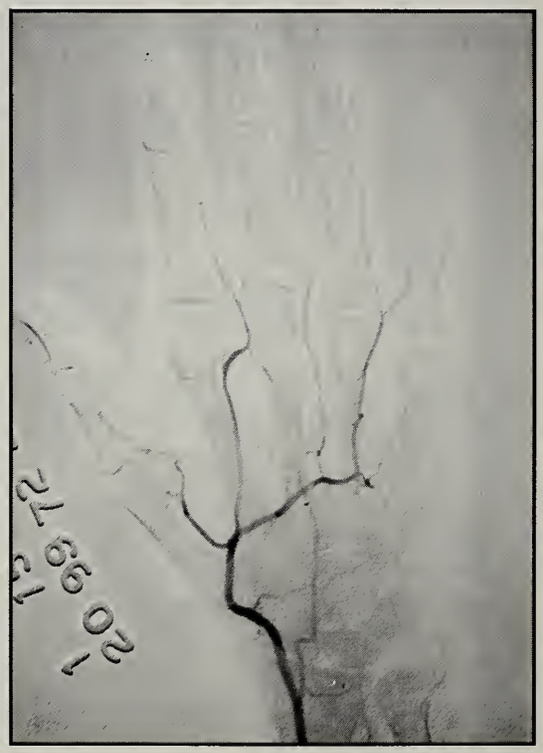

Figure 2: (C.T.) 45 yowf smoker with cold intolerance and severe ischemia of the right hand thumb, index and ring fingers. The index digit demonstrated fixed gangrenous changes. a) Arteriography shows occlusion of both the radial and ulnar arteries (arrows). b) Patient's less symptomatic left hand showed occlusion of the distal ulnar artery. She demonstrated reversible vasospasm with a pre-operative stellate ganglion block and, therefore, underwent a common digital artery sympathectomy.

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Arkansas HIV/AIDS Report 1983-1993

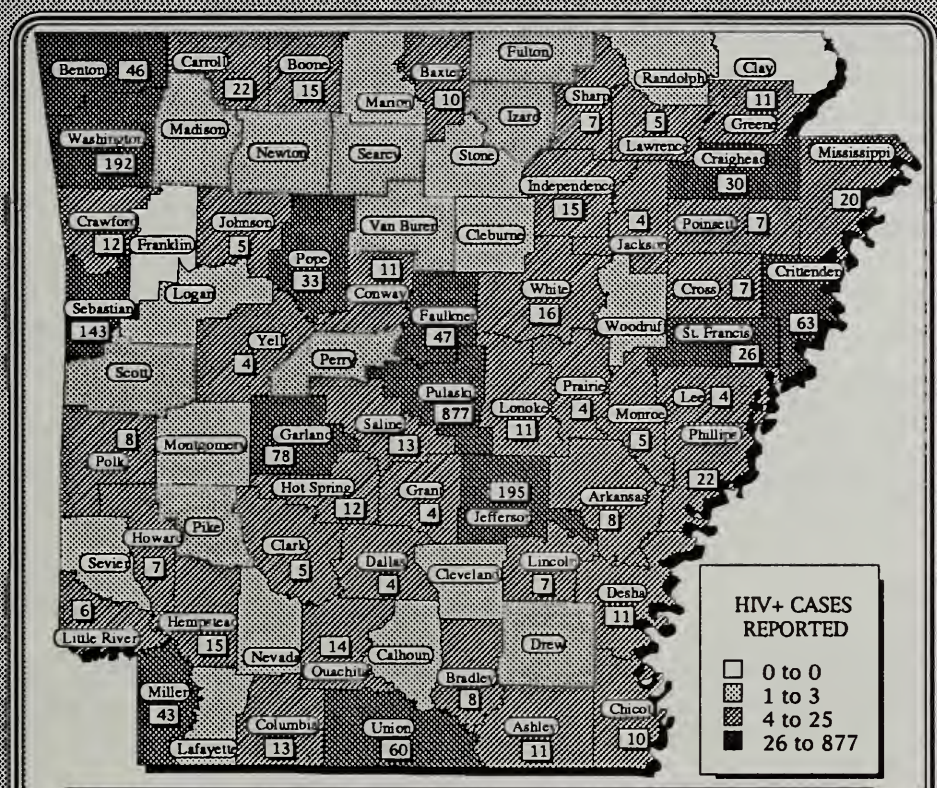
Arkansas: 1983 through March 25, 1993

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	19	32	49	216	251	437	421	408	88	**1,921**	*85.11*
	Female	1	1	6	27	39	72	89	83	18	**336**	*14.89*
AGE	< 5	0	0	1	1	2	9	14	8	0	**35**	*1.55*
	5-12	0	0	0	1	1	5	2	2	1	**12**	*0.53*
	13-19	0	0	0	8	8	14	20	26	2	**78**	*3.46*
	20-29	8	10	15	109	125	192	154	164	42	**819**	*36.29*
	30-39	7	15	22	86	105	206	219	185	41	**886**	*39.26*
	40-49	4	7	11	24	35	62	74	68	15	**300**	*13.29*
	> 49	1	1	6	6	12	19	23	38	5	**111**	*4.92*
	Unknown	0	0	0	8	2	2	4	0	0	**16**	*0.71*
RACE	White	16	24	47	171	178	353	312	302	69	**1,472**	*65.22*
	Black	4	9	8	70	107	153	195	179	34	**759**	*33.63*
	Other/Unknown	0	0	0	2	5	3	3	10	3	**26**	*1.15*
TOTAL HIV+ CASES BY YEAR		**20**	**33**	**55**	**243**	**290**	**509**	**510**	**491**	**106**	**2,257**	*100%*

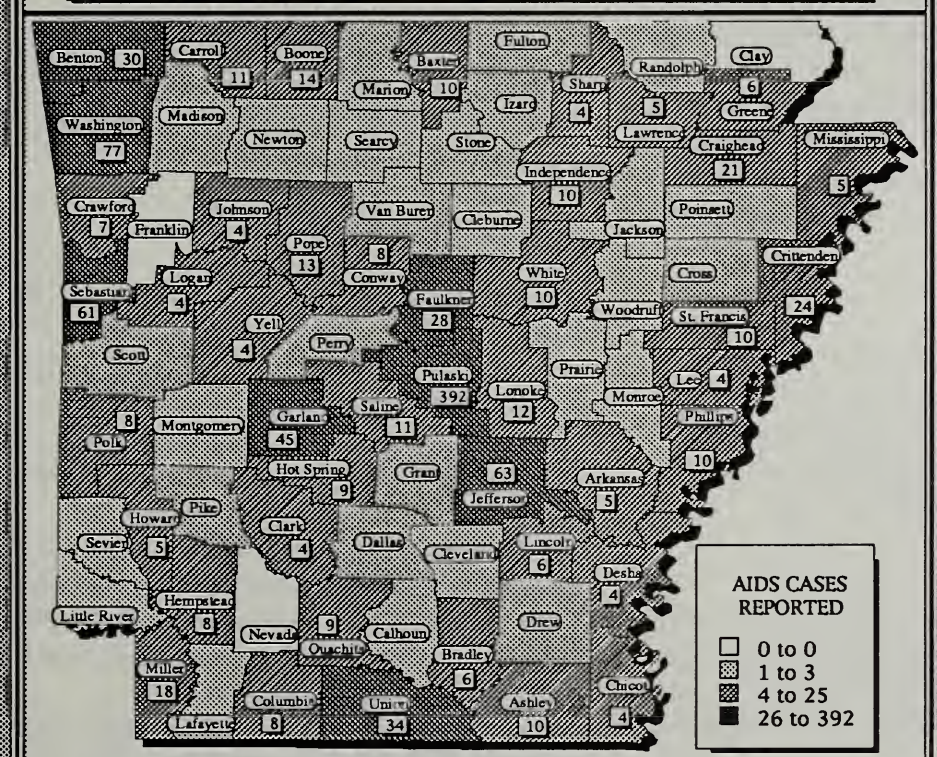
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	147	**975**	*88.16*
	Female	1	0	4	6	10	20	25	35	30	**131**	*11.84*
AGE	< 5	0	0	0	1	1	6	6	3	0	**17**	*1.54*
	5-12	0	0	0	1	0	1	1	0	1	**4**	*0.36*
	13-19	0	0	0	0	0	4	3	2	4	**13**	*1.18*
	20-29	7	9	15	27	24	55	57	81	46	**321**	*29.02*
	30-39	3	13	23	36	41	78	80	128	81	**483**	*43.67*
	40-49	1	6	8	10	7	35	41	52	34	**194**	*17.54*
	> 49	1	0	4	8	7	11	13	19	11	**74**	*6.69*
RACE	White	9	22	43	61	58	141	134	207	132	**807**	*72.97*
	Black	3	6	7	20	21	47	66	74	42	**286**	*25.86*
	Other/Unknown	0	0	0	2	1	2	1	4	3	**13**	*1.18*
RISK	Male/Male Sex	7	17	31	59	50	118	118	177	96	**673**	*60.85*
	Injection Drug User (IDU)	0	2	10	4	11	18	28	40	25	**138**	*12.48*
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	11	**92**	*8.32*
	Heterosexual	2	0	2	3	6	10	10	22	14	**69**	*6.24*
	Transfusion	0	0	2	7	3	7	11	3	3	**36**	*3.25*
	Perinatal	0	0	0	1	1	6	6	3	1	**18**	*1.63*
	Hemophiliac	0	0	0	1	1	5	5	4	5	**21**	*1.90*
	Undetermined	0	0	1	2	2	8	6	18	22	**59**	*5.33*
TOTAL AIDS CASES BY YEAR		**12**	**28**	**50**	**83**	**80**	**190**	**201**	**285**	**177**	**1,106**	*100%*

Source: AIDS Surveillance Unit, Arkansas Department of Health.

Arkansas HIV/AIDS Report 1983-1993



County of residence at the time of test for the 2257 Arkansans reported to be HIV+. (3/25/93)



Of the 2257 Arkansans reported to be HIV+, 1106 have been diagnosed with AIDS. (3/25/93)

Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes sypmtomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.

New Members

BENTON

Enderlin, Annette M, Ophthalmology. Born August 2, 1947. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993. Board certified.

CONWAY

Roberts, Thomas S., Orthopaedics. Born April 22, 1956. Medical education, Louisiana State University, Shreveport, 1982. Internship/Residency, UAMS, 1987. Board certified.

EL DORADO

Perry, Alvis T., Anesthesiology. Born July 20, 1954. Medical education, University of North Carolina, Chapel Hill, 1980. Internship, Fitzsimmons Army Medical Center, 1982. Residency, Brooke Army Medical Center, 1989. Board certified.

FORT SMITH

Bodiford, Gary L., Ophthalmology. Born July 1, 1960. Medical education, UAMS, 1986. Internship, University Hospital, Little Rock, 1987. Residency, University of Texas Medical Branch, Galveston, 1990. Board certified.

Westerfield, Samuel, Anesthesiology. Born November 26, 1946. Medical education, Columbia College of Physicians and Surgeons, New York City, 1974. Internship/Residency, (Peds) Babies Hospital, Columbia University Med Center, 1977. Fellowship, Washington University Sch. Med., St. Louis, Missouri, 1978. Residency, Columbia Presyberterian Medical Center, 1985. Board certified.

HELENA

Athota, Prasad J., General Surgery. Born May 4, 1945. Medical education, Guntur Medical College, India, 1967. Internship, Government General Hospital, Guntur, India 1968. Residency, Wright State University, Dayton, Ohio, 1980. Board certified.

HOPE

Mercer, Moore L.F., Orthopedics. Born January 7, 1944. Medical education, Yale, 1969. Internship, Jackson Memorial Hospital, Miami, Florida, 1970. Residency, Fitzsimon's Army Medical Center, Denver, 1985. Board certified.

HOT SPRINGS

Pilkington, Cheryl E., Family Practice. Born November 1, 1948. Medical education, Oklahoma State University College of Osteopathic Medicine, 1987. Internship, Hillcrest Hospital, Oklahoma City, 1988. Residency, University of Oklahoma, 1990. Board certified.

Sharma, Bimlendra, Cardiology. Born July 15, 1935. Medical education, K.G. Medical College, India, 1960. MRCP, Royal College of Physicians, Scotland, 1967. Board certified.

JONESBORO

Awar, Ziad, Cardiology. Born April 29, 1950. Medical education, American University of Beirut, 1976. Internship/Residency, American University of Beirut, 1977. Residency, University of Tennessee, 1982. Board eligible.

Bolt, Michael E., General Surgery. Born August 17, 1951. Medical education, University of Kansas School of Medicine, 1976. Residency, St. Francis Hospital, 1981. Board certified.

Parten, Dennis D., Family Practice. Born March 26, 1955. Medical education, UAMS, 1985. Internship/Residency, Jonesboro, 1988. Board certified.

Smith, Michael J., Radiology. Born May 3, 1956. Medical education, UAMS, 1981. Residency, UAMS, 1984. Board certified.

LITTLE ROCK

Barber, Laurie D. G.,Ophthalmology. Born June 6, 1959. Medical education, University of Iowa College of Medicine, Iowa City, 1984. Internship/Residency, UAMS, 1990. Board certified.

Biton, Victor, Neurology. Born October 6, 1954. Medical education, Hebrew University, Jerusalem, Israel, 1981. Internship, Beer-Sheva, Israel, 1981. Residency, Hadassah, Jerusalem, Israel, 1986. Board certified.

Glasier, Charles M., Pediatric Radiology. Born August 20, 1951. Medical education, University of Virginia School of Medicine, 1976. Internship/Residency, Wilford Hall USAF Medical Center, 1980. Board certified.

Lynch, Paula M., Psychiatry. Born August 27, 1954. Medical education, Louisiana State University Medical Center, Shreveport, 1978. Internship/Residency, Louisiana State University Medical Center, 1984. Residency, UAMS, 1986. Board certified.

Miller, Michael M., Reproductive Endocrinology and Infertility. Born November 8, 1955. Medical education, Ohio State University, College of Medicine, 1981. Residency, Ohio State University Hospital, 1985. Board certified.

Moffet, Thomas R., Plastic & Reconstructive Surgery. Born January 15, 1957. Medical education, Louisiana State University Medical School, 1982. Internship, Louisiana State University School of Medicine, 1983. Residency, Louisiana State University Medical Center, 1987. Board certified.

Moore, Jim J., Neurological Surgery. Born October 23, 1929. Medical education, UAMS, 1955. Internship, Orange emorial Hospital, Orlando, Florida, 1956. Residency, Baylor Affiliated Program, Houston, Texas, 1963.

Norton, Jim Bliss Jr., Pediatric Cardiology. Born July 17, 1938. Medical education, University of Texas Southwestern Medical School, 1963. Internship/Residency, Children's Medical Center, Dallas, 1966. Board certified.

Reid, Tyra M., Pediatrics. Born January 21, 1953. Medical education, UAMS, 1979. Internship/Residency, UAMS/Arkansas Children's Hospital, 1982. Board certified.

Santoro, Ian H., Cardiology/Electrophysiology. Born March 11, 1958. Medical education, Columbia College of Physicians & Surgeons, New York, 1986. Internship/Residency, University of Chicago, 1989. Board certified.

MARIANNA

Wallace, Charles R., Urology. Born July 3, 1951. Medical education, Howard University School of Medicine, 1978. Internship/Residency, Howard University Hospital, 1983.

MARKED TREE

Huynh, Chanh V., General Practice. Born December 29, 1938. Medical education, Sai Gon Medical University, Viet Nam, 1972. Internship, UAMS, 1982.

PARAGOULD

Collier, Jon D., Radiology. Born June 24, 1947. Medical education, UAMS. Internship, St. Vincent Infirmary, 1974. Residency, Baptist Medical Center, Birmingham, Alabama, 1991.

PINE BLUFF

Jayachandra, Paul D., Internal Medicine/Nephrology. Born July 9, 1952. Medical education, Government Medical College, Mysore, India, 1977. Internship/Residency, Booth Memorial Medical Center, New York, 1991. Board certified.

ROGERS

Tate, Jeffrey L., Psychiatry. Born March 9, 1953. Medical education, Emory University, Atlanta, 1979. Internship/Residency, Emory University Hospitals, 1983. Board certified.

SPRINGDALE

McElroy, Kellye C., Ophthalmology. Born March 20, 1961. Medical education, UAMS, 1987. Internship/Residency, UAMS, 1992. Board certified.

VAN BUREN

Stinson, Harold K., Orthopaedics. Born April 15, 1932. Medical education, University of Manitoba Medical College, Canada, 1957. Internship, St. Boniface Hospital, 1957. Residency, Royal Victoria & Shriners' Hospitals, 1966. Board certified.

WEST MEMPHIS

Kaplan, Bertram D., Dermatology. Born November 1, 1948. Medical education, Jefferson, Philadelphia, Penn., 1974. Internship/Residency, Duke University, North Carolina, 1978. Board certified.

OUT OF STATE

Thomas, Joe A., General Practice, Texarkana, Texas. Born September 15, 1937. Medical education, UAMS, 1963. Internship/Residency, U.S. Naval Hospital, Portsmouth, Virginia, 1968.

RESIDENTS

Robinson, Brent W., Internal Medicine. Born March 8, 1965. Medical education, University of Texas, San Antonio, 1991. Internship/Residency, UAMS.

Spence, Don K., Anesthesia. Born May 25, 1961. Medical education, UAMS, 1987. Internship/Residency, Charlotte, North Carolina, 1990. Residency, UAMS.

STUDENTS

Amanda J. Ferrell
Amy E. McLaurin
Tracy E. Speight

AMS Newsmakers

Dr. Daniel R. Cardwell, a surgeon affiliated with Medical Park Hospital, recently passed his Oral Boards and is now fully Board Certified by the American Board of Surgery.

Dr. R. Lewis Crow, who previously practiced surgery in Pine Bluff, has been named associate medical director for Arkansas Blue Cross and Blue Shield.

Crow joins the company after 18 years of private practice in Little Rock, specializing in cardiovascular and thoracic surgery.

Dr. Henry Vance Kirby has been named a recipient of the National Society Daughters of the American Revolution's Medal of Honor for contributions he has made in preserving American heritage.

Dr. Donald I. Purcell was elected chairman of the board of directors of Security Bank of Paragould at the bank's organizational board meeting. He is a certified radiologist and chief of radiology at Arkansas Methodist Hospital.

Dr. Benjamin Saltzman was recently spotlighted in the Focus cover story, a publication of The Baxter Bulletin. Dr. Saltzman, now retired, was acknowledged in the article for the following achievements: chairman of the steering committee to bring Baxter County Regional Hospital to Mountain Home, president of the state Cancer Society, president of the state Lung Accosiation, president of the state Association for Retarded Citizens, president of the local Rotary (as well as district governor and international director and a member of the board of trustees of the Rotary Foundation), chairman of the state Rural Health Council, chairman of the Department of Family Medicine at UAMS, state Health Officer and health officer for Pulaski County.

Dr. Steven Thomason, family physician from Jonesboro, as been appointed to the Commission of Health Care Services of the American Academy of Family Physicians.

Dr. P. Vasudevan has been elected to the Board of Directors of the First National Bank of Phillips County. Dr. Vasudevan is a urologist in Helena.

The following AMS members were listed as Order of Merit members by the Orthopaedic Research and Education Foundation:

Dr. James A. Arnold
Dr. C. Lowry Barnes
Dr. Banks Blackwell
Dr. & Mrs. Terry G. Green
Dr. & Mrs. Robert R. Gullett, Jr.
Dr. & Mrs. Peter J. Irwin
Dr. Philip H. Johnson
Dr. James M. Kolb, Jr.
Dr. & Mrs. Charles A. Ledbetter
Dr. John O. Lytle
Dr. Claude L. Martimbeau
Dr. Carl L. Nelson, Jr.
Dr. Paul L. Raby
Dr. & Mrs. Thomas S. Roberts
Dr. & Mrs. Bruce L. Smith, Jr.
Dr. Edward R. Weber

The following AMS members are Physician Recognition Award Recipients:

Dr. Jimmy D. Acklin, Fort Smith
Dr. Ramona L. Bates, Little Rock
Dr. Paul J. Baxley, Batesville
Dr. Lindy Book, Little Rock
Dr. Peter C. Dykstra, Mountain Home
Dr. James M. Eaton, Benton
Dr. Robert A. Floss, Hampton
Dr. William T. Harris, Little Rock
Dr. William T. Huskison, Fort Smith
Dr. William N. Jones, Little Rock
Dr. James M. Parker, Little Rock
Dr. Robert D. Quevillon, Walnut Ridge
Dr. John M. Stair, North Little Rock
Dr. James A. Tanner, Little Rock
Dr. Aubrey L. Travis, Van Buren
Dr. Larry W. Weathers, Searcy

Dr. Anna Ridling, Councilor for the Arkansas Medical Society accepts the AMA Membership Award for 1992 on behalf of the Arkansas Medical Society. The award was presented at the National Leadership Conference in February and was given in commemoration of our state's membership growth.

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In Memoriam

Paul N. Means, Sr., M.D.

Dr. Paul N. Means, Sr., of Malvern, died Friday, March 26, 1993. He was 69.

Survivors are his wife, Elizabeth D. Means; a son, Paul N. Means, Jr. of Little Rock; a daughter, Bessie Means of Little Rock; a sister, Esther Abbott of Malvern; and two grandchildren.

Alfie Taliaferro "T" Price Peacock

Alfie Peacock, of Ashdown, died Sunday, March 28, 1993. She was 74.

Survivors are her husband, Dr. N.W. Peacock, Jr.; four sons, N.W. Peacock III of Texarkana, Texas, John C. Peacock of Dumfries, Va., Charles G. Peacock of Roeland Park, Kan., and Richard T. Peacock of Pine Bluff; and five grandchildren.

Medicine in the News

Health Care Access Foundation Update

As of April 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 5,749 medically indigent persons, received 11,581 applications, and enrolled 23,735 persons.

The program has 1,581 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

Over $19,000 Raised for Orthopaedic Research in Arkansas

Banks Blackwell, M.D., Pine Bluff, Medical Director of the Orthopaedic Research and Education Foundation; and Augusto Sarmiento, M.D., Honorary Chairman, have announced the record-breaking results of the 1992 Campaign for the Future of Orthopaedic Surgery. $3,875 million was raised in this nationwide campaign, and $3 million was immediately allocated to fund 58 new grants.

Under Dr. Blackwell's direction, 21 of the state's orthopaedists led the volunteer effort to solicit their colleagues to join the Order of Merit with contributions of $1,000 or more. They enrolled 17 of their fellow orthopaedic surgeons and raised $19,650.

Bumpers Recieves AMA Award

Arkansas Senator Dale Bumpers was chosen by the American Medical Association (AMA) as a recipient of the Dr. Nathan Davis Award for his commitment to excellence in public health service.

Senator Bumpers was one of ten leaders elected by the AMA to be honored at an awards ceremony in Washington, D.C.

Bumpers was recognized for his "comprehensive efforts to improve public health - with initiatives ranging from immunization programs to prenatal care, medical research and expanded rural health clinics," according to the AMA.

"I am honored to have been chosen for this prestigious award," Bumpers said. "When I first became active on preventive health issues as Governor of Arkansas, my wife Betty and I were supremely confident that we could end childhood disease within our lifetimes. I still believe that is possible, but despite all the progress we have made, there is still much work to be done."

"I look forward to continuing the battle for affordable, available health care for all Americans," he added.

Senator Bumpers is a member of the Senate subcommittee that funds health programs, where he is the acknowledged leader on preventive health programs such as nutrition and childhood immunizations. The national child immunization program, which now protects millions of American children, is based on the program he and his wife Betty started in Arkansas in the 1970s.

Health Department Plans Smoking Cessation Program

The Arkansas Department of Health announced the availability of ProStep, a nicotine transdermal system to be used by participants in smoking cessation programs. Lederle Laboratories, makers of ProStep, in conjunction with the Association of State and Territorial Health Offices (ASTHO) will distribute the patches to state, county and local health departments.

According to Dr. Joycelyn Elders, Surgeon General-designate, the Department of Health is looking for community partners for smoking cessation programs. The free patches will be another incentive for smokers to enter a smoking cessation program and could be especially important for those who could not afford them on their own. These partners will help distribute the free ProStep nicotine patches donated by Lederle Laboratories.

The community partners should have ongoing smoking cessation programs or be willing to provide a smoking cessation program in conjunction with use of the nicotine patches. The community partners should agree to meet the following guidelines:

- The target population is low income smokers who would not normally be able to afford nicotine patches.

- The target population is heavy smokers (1 1/2 packs per day or more) who are likely to have nicotine withdrawal symptoms at the time of smoking cessation.

- The nicotine patch will be used as part of a complete cessation program with group sessions, educational information, behavioral modification and follow-up.

Clinics, hospitals, and free-standing smoking cessation programs that are interested in this effort should contact: Joy Rockenbach, Health Education Supervisor, 661-2360.

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BARCODE RE
DOS PARALELL INTERFACE
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ELECTRONIC CLAIMS

STRAIGHT TALK.

SIMPLE SOLUTIONS.

FROM PEOPLE WHO SPEAK

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ARKANSAS EXPRESS CLAIMS

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YOU MAKE THE DIFFERENCE!

In Arkansas, hundreds of physicians, pharmacists, dentists, home health agencies, hospitals and public health agencies have joined forces to support the Arkansas Health Care Access Foundation, Inc. (AHCAF). These providers are part of a unique voluntary effort to provide access to quality health care for low-income Arkansans who do not qualify for government assistance, have no form of health insurance and are living at or below the federal poverty level.

You can help! Thousands of Arkansans are potentially eligible for this safety net program. Therefore, continued support from all sectors of the health care community is essential if we are to meet the growing demand. Volunteering your services ensures timely medical attention for those in need. **You make a difference!**

Since 1989 AHCAF has reached thousands of people and led, by example, in the quest for broader access to medical care. And with your continued support we will ensure the health and welfare of all Arkansans.

For more information on how you can help, call AHCAF at (501) 221-3033 or (800) 950-8233

Arkansas Health Care Access Foundation, Inc.

Things To Come

June 3-5

3rd International Biological Effects of Light Symposium. Wenkenhof Riehen meeting Center, Basel, Switzerland. Sponsored by the Light Symposium Foundation. For more information, call (404) 432-2409.

June 4-5

12th Annual Occupational & Environmental Medicine Symposium. Cancer Center Auditorium, UC Davis Medical Center, Sacramento, CA. For information, call (916) 734-5390.

June 6-11

9th Annual EVMS Family Medicine Review Course. The Cavalier Hotel, Virginia Beach, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

June 11-12

Alzheimer's Disease. Adam's Mark Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

June 12-16

Board Review in Family Practice. Arlington, VA. Sponsored by The George Washington University Medical Center. For more information, contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

June 13-18

17th Annual Fingers to the Toes: Primary Care Orthopaedics. Fallen Leaf Lake (South Lake Tahoe), CA. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. CME credit offered. For more information, call (916) 734-5390.

June 16-20

Sixth International Facial Plastic Surgery Symposium. San Francisco Marriott Hotel. Sponsored by the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery. For more information, contact Rick Ottinger, (202) 842-4500.

June 17

State of the Art Clinical Symposium on Allergic Diseases. The Ritz-Carlton Hotel, St. Louis, Missouri. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, contact program chairman, Phillip E. Korenblat, M.D., at (314) 362-6893 or (800) 325-9862.

June 17-18

Allergic Diseases of the Upper and Lower Airways. Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

Pediatric Transfusion Medicine: Present Practice and Future Directions. Hyatt Regency Bethesda in Bethesda, Maryland. Cosponsored by the AABB and TMAA. For more information, call (301) 215-6382.

June 25-27

11th Summer Symposium in Internal Medicine. Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

June 26

Broaching the Biological Barriers to Transplantation: 4th Annual Rush Symposium on Transplantation. The Inn at University Village on the campus of Rush-Presbyterian-St. Lukes' Medical Center. Registration fee: $150. For more information, call (312) 942-6242.

July 6-10

16th Annual Flap Dissection Workshop. Virginia Beach Conference Center, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

July 15-16

Drug Utilization Review '93. Sheraton Boston Hotel & Towers, Boston, MA. Sponsored by Infoline. For more information, call (508) 481-6400.

July 15-17

First Annual Mid-South Symposium on Cardiovascular Disease. The Laurence A. Grossman Medical Learning Center, Saint Thomas Hospital, Nashville, Tennessee. Sponsored by the American College of Cardiology. 18.5 Category I credit. For more information, call (800) 257-4739 (outside the U.S. and Canada, (301) 897-2695).

July 17-23

18th Annual National Wellness Conference. University of Wisconsin-Stevens Point, Wisconsin. For more information, call (715) 346-2172.

July 18-22

Current Concepts in Cardiology. Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of Continuing Medical Education, UC Davis Medical Center and School of Medicine. 19 hours Category I credit. For more information, call (916) 734-5390.

July 21-25

15th Annual National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum. Houston, TX. Sponsored by The George Washington University Medical Center Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of Continuing Medical Education, (202) 994-4285.

July 27-August 1

55th Annual Meeting of the International College of Surgeons-U.S. Section, held in conjunction with the 33rd North American Federation Congress. Westin Hotel, Seattle, WA. For more information, call (312) 787-6274.

September 10-12

Frontiers in Endosurgery. Washington University Medical Center, St. Louis. 18.5 credit hours Category I. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, contact program chairmen, Ralph V. Clayman, M.D. and Elspeth McDougall, M.D., at (314) 362-6893 or (800) 325-9862.

September 11-14

The Decade of the Brain: An International Conference. The Omni-Shoreham, Washington, D.C. 28 Category I credit hours. For more information contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

October 6-14

Sixth Biennial Allergy Abroad Seminar. Holland and Belgium. For more information, contact Phillip E. Korenblat, M.D. at Washington University Medical Center in St. Louis, Office of Continuing Medical Education, (314) 362-6893 or (800) 325-9862.

Recruiting Physicians

Growing community hospital of 63 beds in the scenic Ozark Mountains in N.W. Arkansas is seeking full time, experienced emergency physicians to staff E.D. Must be BP/BC in EM, FP, or IM with ACLS. $110K+/year. Flexible scheduling. Send C.V. to:

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Hospital Medical Staff Section
21st Assembly Meeting
Chicago Marriott Hotel
June 10-14, 1993

Reform of the American health care delivery system is the issue of the 90s. The public and political debate over changing our health care delivery system is intense. Significant reform legislation has already been passed in several states. To help you lead your organization in a time of major change, three educational programs will be part of this HMSS Assembly Meeting.

Negotiations and Conflict Resolution
Gain new skills to effectively provide leadership in negotiating and resolving conflicts that arise in the process of health care delivery. Learn to frame negotiation in the best interests of all parties, to listen actively, to use positional bargaining and avoid surprises.

Review and Analysis of President Clinton's Health Care Reform Plan
President Clinton is expected to release his new health care reform plan in May. Participants in this session will hear a full review and analysis of the plan from leading experts in the medical field.

Challenge and Change in the Managed Care Environment
Develop a comprehensive understanding of the current environment in health care highlighted by a discussion of the impact of President Clinton's plan on health care delivery system reform. Discover steps physicians can take to deal with the realities of managed care.

Don't miss this opportunity to acquire leadership skills to help your physician community succeed!

For more information, please call 312 464-4754 or 464-4761.

Hospital Medical Staff Section

American Medical Association
Physicians dedicated to the health of America

Keeping Up

Family Medicine Spring Academic Conference

May 21-23, Holiday Inn West, Little Rock. Sponsored by UAMS Department of Family Medicine, Faculty Development Division. For more information contact Dr. Gene Aist at (501) 686-6628.

Envolving Issues in Vascular Biology and Coronary Heart Disease

May 22, 8:30 a.m., UAMS Education II Building, Room G141 A & B, Little Rock. Sponsored by UAMS and presented by Jon P. Lindemann, M.D. 2.75 Category I credit, fee: $25.

9th Annual Surgery Residents Day Conference

May 28, 12 noon, UAMS, ACRC Building, Little Rock. Sponsored by UAMS and presented by Robert W. Barnes, M.D. 3.5 Category I credit.

UAMS College of Medicine Alumni Weekend

June 11-13, Capital and Excelsior Hotels, Little Rock. Sponsored by the Arkansas Caduceus Club, College of Medicine Alumni Association. For more information, call (501) 686-6684.

Arkansas Caduceus Club Scientific Session

June 12, time to be announced, UAMS Education II Building, Little Rock. Sponsored by UAMS. Category I credit available.

Advances in the Management of Benign Prostatic Hyperplasia

June 15, 6:30 p.m., Baxter County Regional Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert P. Nelson, Jr., M.D. 2.0 Category I credit.

1993 Spring Seminar, AHEC-Fort Smith

June 29, 8:00 a.m.-4:45 p.m. & June 30, 8:30 a.m.-12:30 p.m., Holiday Inn Civic Center, Fort Smith. Sponsored by AHEC-Fort Smith. Category I credit to be announced, registration: $75.00.

46th AAFP Annual Scientific Assembly

July 29-August 1, Excelsior Hotel and Statehous Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE-VA MEDICAL CENTER
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER
CME Luncheon for Medical/Dental Staff, May 14 & 28, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon
CME Luncheon, May 14 & 28, 12:30 p.m., AMI Ozark/Quapaw room. 1 hour Category I credit per luncheon

Country Doctor of the Year

America's finest rural physician will be honored as the "Country Doctor of the Year," a new award presented by the Country Doctor Museum in Bailey, North Carolina in association with Staff Care, Inc., an Irving, Texas-based interim physician staffing firm. Nominations for the award will be accepted through July 1, 1993 and may be submitted by physicians, health facility administrators, nurses, patients or relatives of the nominee. Those wishing to nominate a physician may obtain nomination forms by calling Staff Care at (800) 685-2272 or the Country Doctor Museum at (919) 235-4165.

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL
Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.
(THE AIDS CONFERENCE FOR APRIL IS CANCELLED FOR GOOD FRIDAY)

LITTLE ROCK-BAPTIST MEDICAL CENTER
Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL
Chest & Problems Case Conference, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Medicine Conference, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.
Surgery Conference, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.
Tumor Conference, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room
CME Outreach Program, dates, times & locations vary
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29

GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C
Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m.,VAMC-LR, 4D
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D
Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D
Urology Pathology Conference, 4th Thursday, 5:00 p.m., VAMC-LR, 4D
Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2
Urology Pre-op/Didactic Conference, Mondays, 5:00 p.m., VAMC-LR, 4D
Urology Radiology Conference, 1st Thursday, 5:00 p.m., UAMS, Radiology Department
Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D
Urology VA Teaching Rounds, every Friday, 7:30 a.m., VAMC-LR, 4D
Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142
White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

EL DORADO-AHEC
Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas
Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital

Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC - South Arkansas
Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas
Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

FAYETTEVILLE-AHEC NORTHWEST
AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Fridays, 12:00 noon, Washington Regional Medical Center
AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

FORT SMITH-AHEC
Advances in Plastic Surgery, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith
Gastroenterology Conference, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center
Neuroradiology Conference, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Osteoporosis, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith
Sparks Tumor Conference, Tuesdays, 12:00 noon, Sparks Regional Medical Center
Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST
AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould
Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn
Clinical Faculty Conference, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided
Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club
Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC
Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST
Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center
Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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